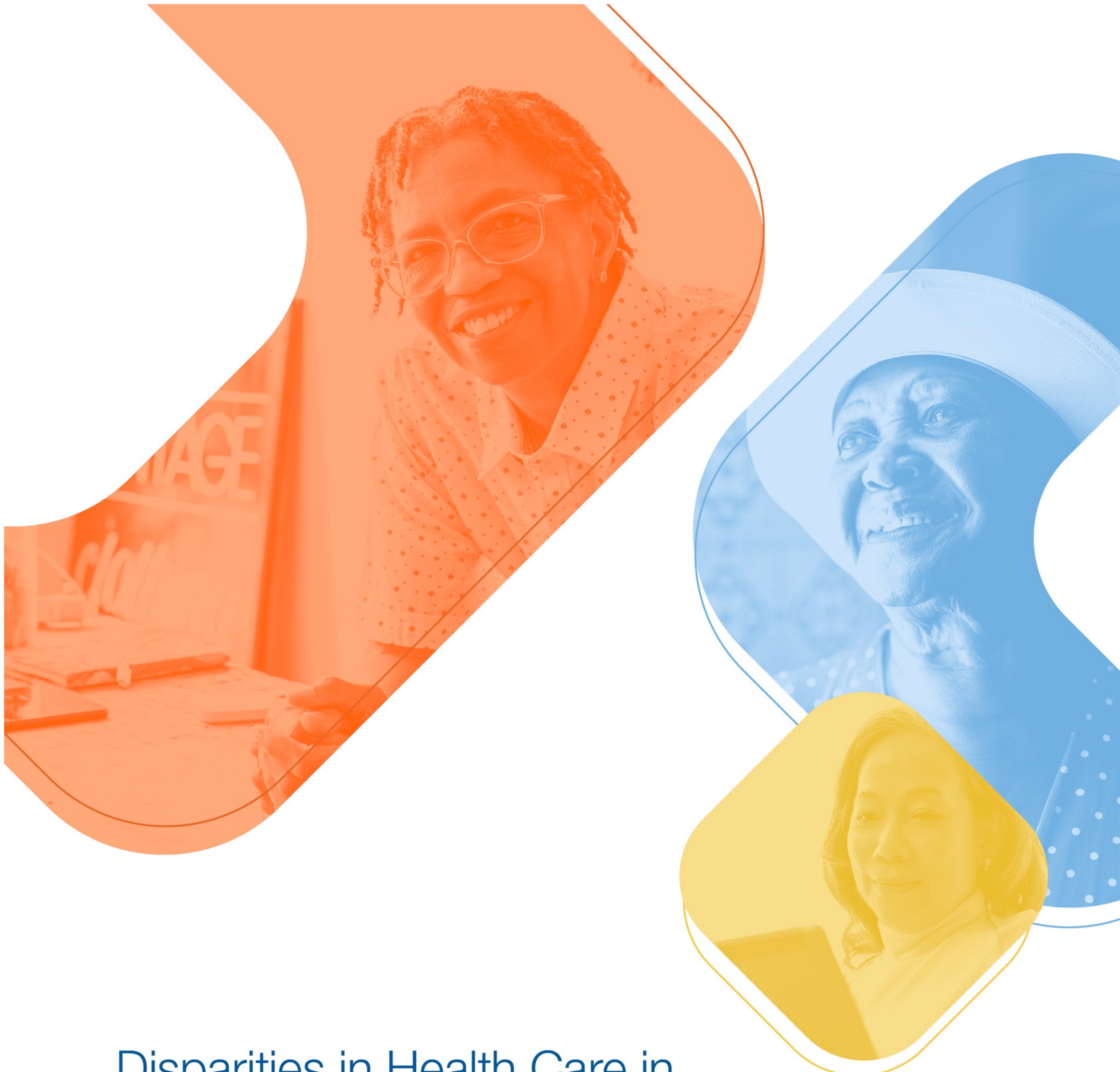


Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex

APRIL 2024

CMS Office of Minority Health in Collaboration with The RAND Corporation

CMS

About This Report

This report presents summary information on the quality of health care received by Medicare Advantage enrollees nationwide, highlighting racial, ethnic, and sex differences in health care experiences and clinical care.

This research was funded by the Centers for Medicare & Medicaid Services and carried out within the Quality Measurement and Improvement Program in RAND Health Care.

RAND Health Care, a division of RAND, promotes healthier societies by improving health care systems in the United States and other countries. We do this by providing health care decisionmakers, practitioners, and consumers with actionable, rigorous, objective evidence to support their most complex decisions. For more information, see www.rand.org/health-care, or contact

RAND Health Care Communications
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
(310) 393-0411, ext. 7775
RAND_Health-Care@rand.org

Contents

About This Report iii
Executive Summary vii
Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex 1
Patient Experience and Clinical Care Measures Included in This Report 9
Abbreviations Used in This Report 11
Overview of Appendices........ 18
Appendix A: Disparities in Health Care in Medicare Advantage by Race and Ethnicity 21
- Disparities in Care by Race and Ethnicity: All Patient Experience Measures........ 22
- Patient Experience 24
- Disparities in Care by Race and Ethnicity: All Clinical Care Measures 38
- Clinical Care: Prevention and Screening........ 42
- Clinical Care: Respiratory Conditions 46
- Clinical Care: Cardiovascular Conditions 52
- Clinical Care: Diabetes........ 64
- Clinical Care: Musculoskeletal Conditions........ 76
- Clinical Care: Behavioral Health 80
- Clinical Care: Medication Management and Care Coordination 96
- Clinical Care: Overuse and Appropriate Use of Medication 106
- Clinical Care: Access to and Availability of Care 122

Appendix B: Disparities in Health Care in Medicare Advantage by Sex 124
- Disparities in Care by Sex: All Patient Experience Measures........ 125
- Patient Experience 126
- Disparities in Care by Sex: All Clinical Care Measures 133
- Clinical Care: Prevention and Screening........ 135
- Clinical Care: Respiratory Conditions 136
- Clinical Care: Cardiovascular Conditions 139
- Clinical Care: Diabetes........ 143
- Clinical Care: Behavioral Health 149
- Clinical Care: Medication Management and Care Coordination 157
- Clinical Care: Overuse and Appropriate Use of Medication 162
- Clinical Care: Access to and Availability of Care 170

Appendix C: Disparities in Health Care in Medicare Advantage by Race and Ethnicity Within Sex 171
- Racial and Ethnic Disparities in Care by Sex: All Patient Experience Measures........ 172
- Patient Experience 175

Racial and Ethnic Disparities in Care by Sex: All Clinical Care Measures 189
Clinical Care: Prevention and Screening 195
Clinical Care: Respiratory Conditions 197
Clinical Care: Cardiovascular Conditions 203
Clinical Care: Diabetes 215
Clinical Care: Behavioral Health 227
Clinical Care: Medication Management and Care Coordination 243
Clinical Care: Overuse and Appropriate Use of Medication 253
Clinical Care: Access to and Availability of Care 269
Appendix D: Data Source and Methods 271
References 276

Executive Summary

This report presents summary information on the quality of health care received by Medicare Advantage (MA) enrollees nationwide in 2023. The report highlights (1) differences in health care experiences and clinical care by race and ethnicity of enrollees, (2) differences in health care experiences and clinical care by sex of enrollees, and (3) how racial and ethnic differences in quality of care vary by sex of enrollees. This information might be of interest to people with Medicare, MA organizations, Medicare Part D sponsors, advocacy organizations, and federal policymakers.

The report is based on an analysis of two sources of information: the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, which focus on the health care experiences of people with Medicare, and the Healthcare Effectiveness Data and Information Set (HEDIS®), which focuses on the clinical quality of care that people with Medicare receive for a variety of medical issues. In all, seven patient experience measures and 41 clinical care measures were examined. Measures were chosen based on their reliability, validity, and informativeness for making comparisons across racial and ethnic groups (Martino et al., 2013).

Overall, the analysis found few practically significant differences from the national average on measures of patient experience across racial and ethnic groups but fairly widespread racial and ethnic differences on clinical care measures. Across racial and ethnic groups, there were few noteworthy differences in scores by sex on either the patient experience or the clinical care measures; though, this analysis did find that male Multiracial MA enrollees fared worse than female Multiracial enrollees on measures of patient experience.

Key Findings:

- Some disparities exist between patient experiences; most groups—except for Asian American and Native Hawaiian or other Pacific Islander (AA and NHPI) MA enrollees—showed disparities in 1 or 2 of 7 total measures. Scores for AA and NHPI MA enrollees were lower on most patient experience measures (5 of 7), but the interpretation of this finding is complicated because Asian American respondents are known to use response scales for CAHPS items differently from how other racial and ethnic groups use them (Mayer et al., 2016). There was variation across racial and ethnic groups on which patient experience measures were below the national average. Two or more race or ethnicity groups were below the national average on three measures—Getting Appointments and Care Quickly, Getting Needed Prescription Drugs, and Annual Flu Vaccine—which suggests possible barriers in access to care.
- Disparities on clinical care measures were more widespread. Scores for American Indian/Alaska Native (AI/AN), Black, and Hispanic MA enrollees were below the national average on large proportions of the clinical care measures that were investigated, such as measures in the diabetes care, behavioral health care, and overuse and appropriate use of medications domains. In contrast, scores for AA and NHPI MA enrollees were above the national average on a large proportion of the clinical care measures, and scores for White MA enrollees were almost always similar to the national average.
- Disparities were most common for AI/AN MA enrollees and Black MA enrollees, and those disparities spanned across multiple areas of clinical care. For AI/AN enrollees, scores on measures in the diabetes care domain were notably below average. For Black MA enrollees, scores on measures in the areas of behavioral health, cardiovascular care, diabetes care, and care coordination were notably below average.
- Clinical care results for AA and NHPI MA enrollees and Hispanic MA enrollees were mixed. Scores for AA and NHPI enrollees were above the national average on 13 of 41 measures (compared with below the national average on 5 of 41). Scores for Hispanic MA enrollees were above the national average on 12 of 41 measures (compared with below the national

average on 11 of 41). For AA and NHPI MA enrollees scores on measures related to alcohol and other drug (AOD) dependence treatment were notably below average. For Hispanic MA enrollees scores on measures of AOD Dependence Treatment and Engagement in Cardiac Rehabilitation measures were notably below average.

- Scores for male and female MA enrollees on patient experience and clinical care measures were generally similar. However, male Multiracial enrollees had lower than average patient experience scores more often (4 of 7) than did female Multiracial enrollees (1 of 7).
- Patterns of disparities were similar to those in the 2023 Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex report. One exception was that in the previous year's report female Multiracial enrollees had lower than average patient experience measures more often (3 of 7) than male Multiracial enrollees (1 of 7).

Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex

Introduction

The National Academy of Medicine (formerly the Institute of Medicine) has identified the equitable delivery of care as a hallmark of quality (Institute of Medicine, 2001). Assessing equitability in the delivery of care requires making comparisons of quality by personal characteristics of patients, such as race, ethnicity, and sex. Three sets of such comparisons are presented in this report, which focuses on MA enrollees nationwide. In the first set, quality of care for six racial and ethnic groups—AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White MA enrollees—is compared with quality of care for all MA enrollees combined (i.e., the national average). In the second set of comparisons, quality of care for female and male MA enrollees is compared with quality of care for all MA enrollees combined. In the third set, quality of care for MA enrollees by racial and ethnic group is compared with quality of care for all MA enrollees by sex.

As in the prior reports in this series, the three sets of comparisons just described—which might be of interest to people with Medicare, MA organizations, Medicare Part D sponsors, advocacy organizations, and federal policymakers—are being presented in a single report to provide a comprehensive understanding of the ways in which care differs by race and ethnicity, sex, and the intersection of these characteristics. The focus of this report is on differences at the national level. Interested readers can find information about health care quality for specific Medicare plans (more specifically, contracts) at Medicare.gov (Medicare.gov, undated) and information about racial and ethnic differences in health care quality within Medicare plans on the Stratified Reporting page at CMS.gov (Centers for Medicare & Medicaid Services [CMS], 2023f).

Data Sources

The report is based on an analysis of two sources of information. The first source is the Medicare CAHPS surveys, which are conducted annually by the CMS and focus on the health care experiences (e.g., ease of getting needed care, how well providers communicate, ease of getting needed prescription drugs) of people with Medicare across the country. These surveys also contain a patient-reported measure of receiving a flu immunization in the past year.

The second source of information is HEDIS, which is composed of information collected from medical records and administrative data on the clinical quality of care that people with Medicare receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. In this report, clinical care measures are grouped into nine categories: prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse and appropriate use of medication, and access to and availability of care.

Unlike CAHPS data, HEDIS data do not have enrollees' self-reported race and ethnicity linked to them. Instead, analysis of HEDIS measures relies on a method of imputing race and ethnicity that combines information from CMS administrative records with other data sources. This method, known as Medicare Bayesian Improved Surname and Geocoding, matches self-reported data on race and ethnicity with 85–99 percent concordance (see Appendix D for more detail).

Scores on patient experience measures are reported for each of six racial and ethnic groups whenever the reporting criteria specified in Appendix D are met. Those six groups are AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White. Scores on clinical care measures are reported for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees whenever the reporting criteria specified in Appendix D are met.

The algorithm used to predict racial and ethnic group membership for the clinical care data is not accurate enough to permit reporting of scores for the Multiracial group.[1]

Three of the clinical care measures presented in this report, one of which pertains to breast cancer screening and two of which pertain to osteoporosis, are specific to female patients. Thus, the set of comparisons by sex and the set of comparisons by race and ethnicity within sex exclude these three measures. Two other clinical care measures, both of which deal with statin therapy for patients who have cardiovascular disease, are defined differently for female and male patients and thus are excluded from the set of comparisons by sex.

Whereas all patient experience measures are applicable to people with Medicare aged 18 years and older, certain HEDIS measures apply to people in a more limited age range. These instances are noted throughout the report.

A comprehensive list of the seven patient experience and 41 clinical care measures is provided in the section titled "Patient Experience and Clinical Care Measures Included in This Report." In keeping with official scoring practices, scores on CAHPS measures are case mix–adjusted (see Appendix D for details), whereas scores on HEDIS measures are not.

The report uses data reported in 2023. The CAHPS data pertain to care experiences reported on the 2023 Medicare CAHPS survey, which was fielded from March to June 2023. Respondents were asked about care received in the six months prior to their completing the survey. HEDIS data reported in 2023 (referred to as *Reporting Year 2023* in this report) correspond to care received from January to December 2022.[2]

Previous versions of this report, which are available on the Stratified Reporting page at CMS.gov (CMS, 2023f), presented information on the quality of care received by MA enrollees nationwide based on data reported in 2016, 2017, 2018, 2019, 2021, and 2022. Because of the coronavirus disease 2019 (COVID-19) pandemic, the CAHPS surveys were not fielded in 2020 and HEDIS data were not gathered from (i.e., reported by) MA plans in that year.

The set of patient experience measures presented in this report is the same as the set reported on in the 2018–2023 reports (reporting 2016, 2017, 2018, 2019, 2021, and 2022 data). Two clinical care measures that were included in the 2023 report, Diabetes Care—Blood Sugar Testing and Diabetes Care—Kidney Disease Monitoring, were excluded from this report because they were retired from HEDIS effective Reporting Year 2023. Six clinical care measures are presented in this report for the first time: Initiation of Cardiac Rehabilitation, Engagement of Cardiac Rehabilitation, Kidney Disease Evaluation for Patients with Diabetes, Osteoporosis Screening in Older Women, Medication Adherence for People with Schizophrenia, and Pharmacotherapy for Opioid Use Disorder. The first five of these measures debuted in HEDIS Reporting Year 2022; the sixth debuted in HEDIS Reporting Year 2023.

In 2023, 51 percent of all people with Medicare were enrolled in an MA plan (Ochieng et al., 2023). Enrollment in MA has increased rapidly in recent years, particularly among Black and Hispanic people

---

[1] Details on this algorithm can be found in Appendix D. Race and ethnicity are self-reported on the CAHPS survey, so the issue of reliability of racial and ethnic data does not apply to the patient experience measures reported here.

[2] HEDIS data include the 50 states; Washington, D.C.; and U.S. territories, whereas the CAHPS data are limited to the 50 states; Washington, D.C.; and Puerto Rico.

with Medicare (Meyers et al., 2021). Therefore, disparities in care in MA have taken on heightened significance.

Table 1 shows the distribution of race, ethnicity, and sex in the 2023 MA population compared with the Medicare fee-for-service (FFS) population. Outside the parentheses are column percentages. Inside the parentheses are row percentages. AA and NHPI, Black, Hispanic, and Multiracial people with Medicare were more likely to be enrolled in MA than were AI/AN and White people with Medicare, and female people with Medicare were more likely to be enrolled in MA than were male people with Medicare.

Table 1. Distribution of the 2023 Medicare Advantage and Fee-for-Service Populations

Characteristic	MA, Percentage	Medicare FFS, Percentage
Race or ethnicity		
AI/AN	0.6 (38.9)	0.8 (61.1)
AA and NHPI	4.6 (49.1)	4.0 (50.9)
Black	11.4 (55.2)	7.8 (44.8)
Hispanic	12.9 (63.1)	6.3 (36.9)
White	68.8 (42.0)	79.7 (58.0)
Multiracial	1.6 (49.2)	1.4 (50.8)
Sex		
Female	56.3 (47.7)	52.2 (52.3)
Male	43.7 (43.6)	47.8 (56.4)

NOTE: Row and column percentages may not sum to 100 percent because of rounding.

Disparities in Health Care in Medicare Advantage by Race and Ethnicity—Results Summary

AI/AN MA enrollees reported experiences with care that were similar to the national average on all seven patient experience measures (see Figure 1).[3] AA and NHPI MA enrollees reported care that was worse than the national average on five measures, similar to the national average on one measure (Care Coordination), and above the national average on one measure (Annual Flu Vaccine).[4] Black MA enrollees reported care that was below the national average on one measure (Annual Flu Vaccine) and similar to the national average on six measures. Hispanic MA enrollees also reported care that was below the national average on one measure (Getting Appointments and Care Quickly) and similar to the national average on six measures. Multiracial MA enrollees reported care that was below the national average on two measures (Getting Needed Prescription Drugs and Annual Flu Vaccine) and similar to the national

[3] Here, we describe scores as being above or below the national average if the difference is statistically significant and exceeds a magnitude threshold, as described in Appendix D. We characterize a score as *similar to* the national average if the difference is not statistically significant, falls below a magnitude threshold, or both.

[4] Interpretation of these results is complicated because of a known tendency of Asian American respondents to use response scales for CAHPS items differently from how other racial and ethnic groups use them. When asked to evaluate the care described in standardized clinical vignettes, Asian American respondents are less likely to use response options at either the bottom or top of the scale compared with White respondents (Mayer et al., 2016). Mean CAHPS scores are generally high, so this difference in scale use generally manifests as lower mean responses among Asian American survey respondents compared with White respondents. No comparison of CAHPS response scale use between Native Hawaiian or other Pacific Islander and Asian American respondents has been published. However, because Native Hawaiians and Pacific Islanders constitute a small proportion of the AA and NHPI group, CAHPS scores for this group are largely determined by responses from Asian Americans.

average on five measures. White MA enrollees reported care that was similar to the national average on all measures.

Racial and ethnic differences were more evident for the 41 clinical care measures presented in this report than for the seven patient experience measures (see Figure 2). Scores for AI/AN MA enrollees were below the national average on 10 clinical care measures, similar to the national average on 16 measures, and above the national average on one measure.[5] Scores for AA and NHPI MA enrollees were below the national average on five clinical care measures, similar to the national average on 23 measures, and above the national average on 13 measures. Scores for Black MA enrollees were below the national average on 18 clinical care measures, similar to the national average on 20 measures, and above the national average on three measures. Scores for Hispanic MA enrollees were below the national average on 11 clinical care measures, similar to the national average on 18 measures, and above the national average on 12 measures. Scores for White MA enrollees were similar to the national average on 39 measures and above the national average on two measures.[6] Patterns observed for both CAHPS and HEDIS measures are remarkably similar to ones observed in 2022.

Disparities in Health Care in Medicare Advantage by Sex—Results Summary

Scores for female and male MA enrollees were similar to the national average for all measures of patient experience (see Figure 3). Scores for female enrollees were similar to the national average for all clinical care measures.[7] Scores for male enrollees were below the national average on one clinical care measure (Follow-Up After Hospital Stay for Mental Illness), similar to the national average on 29 measures, and above the national average on three measures (all pertaining to the avoidance of potentially harmful medication use; see Figure 4).[8] These findings are also highly similar to the ones observed in 2022.

Disparities in Health Care in Medicare Advantage by Race and Ethnicity Within Sex—Results Summary

As in Reporting Year 2022, patterns of racial and ethnic differences (compared with the national average) in patient experience were largely similar for female and male MA enrollees (see Figure 5). The one exception was that male Multiracial MA enrollees reported care that was below the national average for all male MA enrollees on four measures, whereas female Multiracial MA enrollees reported care that was below the national average for all female MA enrollees on one measure. Interestingly, in 2022, female Multiracial MA enrollees were more likely than male Multiracial enrollees to report care experiences that were below the national average for their sex.

---

[5] For AI/AN MA enrollees, only a subset of the clinical care measures met reportability criteria, as described on page 271.

[6] For reporting HEDIS data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates of membership in the Multiracial group are less accurate than estimates for other racial and ethnic groups; thus, this report does not show scores for Multiracial MA enrollees on the HEDIS measures.

[7] Two clinical care measures, Breast Cancer Screening and Osteoporosis Management in Women Who Had a Fracture, pertain to only female MA enrollees and so were not eligible for stratified reporting by sex. Two other measures, Statin Use for Cardiovascular Disease and Medication Adherence for Cardiovascular Disease—Statins, are defined differently for females and males and thus also were not eligible for stratified reporting by sex.

[8] When only two groups are compared, scores for the larger group—in most cases here, female MA enrollees—will always be closer to the overall (national) average than scores for the smaller group. This is because the larger group has a greater influence on the overall average. For example, if Group A contains two-thirds of MA enrollees and Group B contains one-third of MA enrollees, then the overall average will be half as far from Group A's score than from Group B's score.

As in Reporting Year 2022, patterns of racial and ethnic differences (compared with the national average) in clinical care were largely similar for female and male MA enrollees (see Figure 6).

Synthesis of Findings

This report focuses on national racial, ethnic, and sex differences in patient experience and clinical quality of care in MA. This information might be of interest to MA organizations and Medicare Part D sponsors as they consider strategies to improve quality of care, including the quality of care received by underserved groups.

Practically significant differences from the national average on measures of patient experience were fairly uncommon across racial and ethnic groups, with the exception of AA and NHPI enrollees. However, interpretation of this finding is complicated because Asian American respondents are known to use response scales for CAHPS items differently from how other racial and ethnic groups use them (see footnote on p. 4).

Disparities on clinical care measures were more widespread. Scores for AI/AN and Black MA enrollees were below the national average on a large proportion of clinical care measures for which these groups met sample size requirements (37 percent and 44 percent, respectively); these scores were almost never above the national average. The area of clinical care in which AI/AN MA enrollees most consistently had below average scores was diabetes care (3 of 3 measures); these deficits were all 7 percentage points or greater. The areas of clinical care in which Black MA enrollees most consistently had below average scores were behavioral health care (6 of 8 measures), cardiovascular care (5 of 6 measures), diabetes care (3 of 6 measures), and care coordination (3 of 5 measures). For this group, the largest deficits were in behavioral health care (scores on 4 measures were 8 or more percentage points below the national average).

Clinical care scores for AA and NHPI and Hispanic MA enrollees were more mixed. Scores were more often above the national average (32 percent of all measures) than below the national average (12 percent) for AA and NHPI MA enrollees whereas scores were about equally likely to be above and below the national average for Hispanic MA enrollees (29 percent versus 2 percent, respectively). For AA and NHPI MA enrollees, the largest deficit was for initiation of AOD dependence treatment (a 10-percentage point deficit); scores for this group were highest for kidney health evaluation for patients with diabetes (16 percentage points above the national average), avoidance of potentially harmful drug-disease interactions in older patients with a history of falls (10 percentage points above the national average), and osteoporosis management in older women (9 percentage points above the national average). For Hispanic MA enrollees, the largest deficits were for initiation of AOD dependence treatment and engagement in cardiac rehabilitation (13 and 9 percentage points below the national average, respectively); the highest score for this group, relative to the national average, was for osteoporosis management in older women (9 percentage points above the national average).

Across racial and ethnic groups, there were few noteworthy differences in scores by sex on either the patient experience or the clinical care measures. However, this analysis did find that male Multiracial MA enrollees fared worse than female Multiracial MA enrollees on measures of patient experience.

Policy and Program Implications: Actions to Eliminate Disparities in Health Care Access, Quality, and Outcomes

Addressing Disparities in Patient Experience: Barriers to Getting Timely Care, Prescription Drugs, and Annual Flu Vaccinations

Data from 2023 patient experience surveys indicate that AA and NHPI and Hispanic MA enrollees experienced difficulty with Getting Appointments and Care Quickly, while AA and NHPI and Multiracial MA enrollees had difficulty in Getting Needed Prescription Drugs. MA enrollees who were Black and Multiracial had flu vaccination rates that were considerably below the national average. Recent policy changes have tried to address these access barriers and hold promise for minimizing or eliminating disparities in these areas. For example, CMS recently finalized several regulatory changes to address concerns regarding MA organizations' use of prior authorization and its potential effect on enrollee access to care, such as requiring that an approval of a prior authorization request remains valid for as long as medically necessary to avoid disruptions in care and requiring that, if an MA organization expects to issue a partial or full denial of a prior authorization request, the decision must be reviewed by a physician or other health care professional with expertise that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, before the denial is issued. Based on statutory changes (CMS, 2023a), CMS also recently expanded eligibility for a full low-income subsidy benefit under which eligible enrollees will have no deductible, no premiums (if enrolled in a benchmark plan) and fixed, lowered copayments for certain medications under Medicare Part D (CMS, 2023a).

Given the role that factors such as preferred language and social drivers of health play on individuals' ability to understand and act on new information related to their health and health care, it is important that information that is distributed is written in a manner that is understandable and for that information to be available in multiple languages. Health care organizations can ensure that patient navigators, community health workers, and frontline staff are equipped to support their patients who might not know how to secure prior authorization, how to access subsidies or cost sharing for prescription drugs, and that vaccines are available at no additional cost. Outreach and education about these new opportunities can help individuals who report difficulty obtaining needed care or needed prescription medications have better experiences with the health care system and prevent the gaps in patient experience between groups from widening.

Addressing Disparities in Clinical Care: Diabetes and Behavioral Health

Approximately 1 in 10 Americans overall and 1 in 4 Americans aged 65 or older have been diagnosed with Type 1 or Type 2 diabetes (Centers for Disease Control and Prevention, 2020; Villarroel et al., 2015). HEDIS data show that Black MA enrollees had notably lower than average scores on Diabetes Care—Blood Sugar Controlled and Diabetes Care—Blood Pressure Controlled; AI/AN and Black MA enrollees had greater challenges with Medication Adherence for Diabetes—Statins.

CMS covers services to help prevent complications from diabetes and forestall onset of diabetes among those with prediabetes (CMS, 2021; CMS 2022). For example, Medicare enrollee cost-sharing for Part B- and D-covered insulin is now capped at $35 per month's supply of covered insulin (CMS, 2023b). CMS also covers self-management training for eligible enrollees and other resources for people living with diabetes (CMS, 2022) as well as for providers who treat patients with this disease (CMS, 2023c). Likewise, the Agency for Healthcare Research and Quality has complied information on a variety of evidence-based treatment practices and quality improvement strategies for providers treating individuals with diabetes (Agency for Healthcare Research and Quality, undated).

related wounds. Health care organizations can also educate providers about evidence-based treatments for diabetes and effective quality improvement strategies.

About 1 in 4 people with Medicare has a mental health condition (Figueroa et al., 2020)—most commonly anxiety or a mood disorder—but most (50 to 60 percent) do not receive treatment (McGinty, 2023). Several behavioral health-related disparities were observed. For example, AI/AN, Black, and Hispanic enrollees had challenges with management of antidepressant medications, in both the acute and continuation phases of treatment. AA and NHPI enrollees had lower than average scores on measures related to AOD, including Initiation of AOD Dependence Treatment and Follow-Up After ED [Emergency Department] Visit for AOD Abuse or Dependence (within 30 days of discharge).

Medicare covers a variety of mental health services and treatments (McGinty, 2023), including intensive outpatient program services for behavioral health conditions (CMS, 2023e), and this coverage is expanding. For example, CMS proposed several policy changes to expand the Medicare behavioral health care workforce and improve enrollees' access to behavioral health care, such as coverage of mental health counselor and marriage and family therapist services (CMS, 2024b). CMS also recently announced the Innovation in Behavioral Health Model to improve quality of care for Medicare and Medicaid enrollees with mental health and substance use disorders. Through this model, CMS aims to support innovative approaches to connect people with the physical, behavioral, and social supports they need to manage these conditions (CMS, 2024a).

Health care organizations can work with patient navigators, community health workers, and frontline staff to (1) identify and connect patients with culturally and linguistically tailored behavioral and social supports available in the community to help manage these conditions, (2) monitor acute and ongoing adherence to treatment, and (3) help patients access services and programs for which they are eligible. Health care organizations can also educate providers about the importance of screening patients for mental health problems, as well as effective treatments and quality improvement strategies.

Patient Experience and Clinical Care Measures Included in This Report[9]

Patient Experience (CAHPS) Measures

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Doctors Who Communicate Well
- Care Coordination
- Getting Needed Prescription Drugs
- Annual Flu Vaccine[10]

Clinical Care (HEDIS) Measures

Prevention and Screening

- Breast Cancer Screening[11]
- Colorectal Cancer Screening

Respiratory Conditions

- Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Cardiovascular Conditions

- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Statin Use in Patients with Cardiovascular Disease[12]
- Medication Adherence for Cardiovascular Disease—Statins[13]
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation

Diabetes

- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Kidney Health Evaluation for Patients with Diabetes

[9] This report considers a larger set of HEDIS measures than the one used in the CMS Part C and D Star Ratings program.
[10] The annual flu vaccine measure is included in the CAHPS survey and is thus grouped with other CAHPS measures in this report.
[11] This measure is specific to female patients and is therefore not included in the set of comparisons by sex.
[12] This measure is defined differently for male and female patients and therefore is not included in the set of comparisons by sex. It is, however, included in the set of comparisons by race and ethnicity within sex.
[13] This measure is defined differently for male and female patients and therefore is not included in the set of comparisons by sex. It is, however, included in the set of comparisons by race and ethnicity within sex.

Musculoskeletal Conditions

- Osteoporosis Screening in Older Women[14]
- Osteoporosis Management in Women Who Had a Fracture[15]

Behavioral Health

- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After Emergency Department (ED) Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Engagement of AOD Dependence Treatment

Medication Management and Care Coordination

- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Overuse and Appropriate Use of Medication

- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls
- Avoiding Use of High-Risk Medications in Older Adults
- Avoiding Use of Opioids at High Dosage
- Avoiding Use of Opioids from Multiple Prescribers
- Avoiding Use of Opioids from Multiple Pharmacies
- Pharmacotherapy for Opioid Use Disorder

Access to and Availability of Care

- Adult Access to Preventive and Ambulatory Services

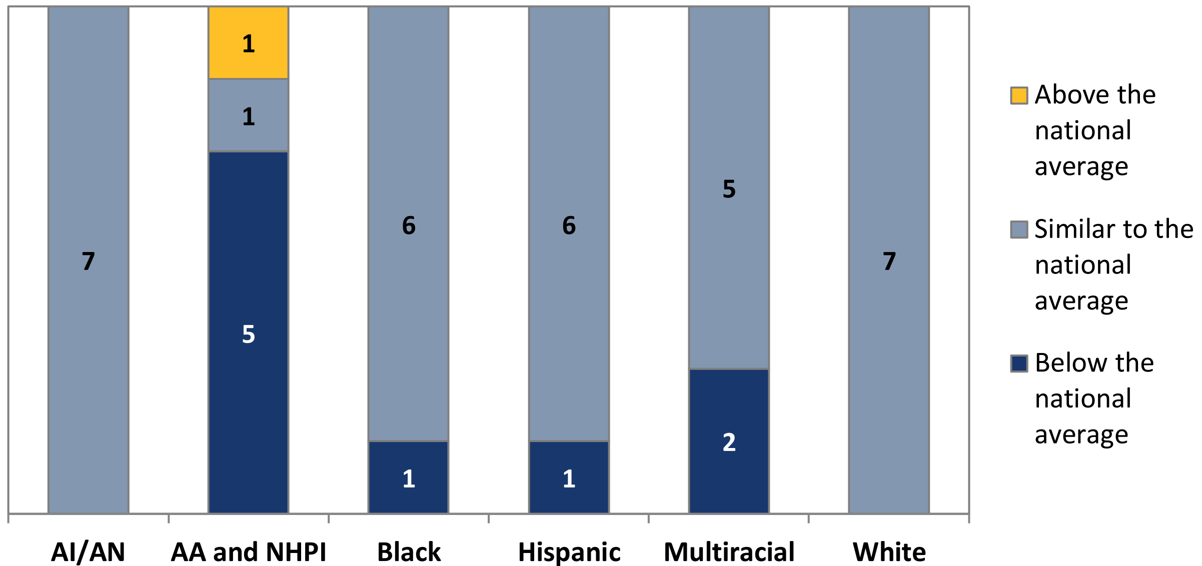
[14] This measure is specific to female patients and is therefore not included in the set of comparisons by sex.
[15] This measure is specific to female patients and is therefore not included in the set of comparisons by sex.

Abbreviations Used in This Report

AA and NHPI	Asian American and Native Hawaiian or other Pacific Islander
AI/AN	American Indian and Alaska Native
AMI	acute myocardial infarction
AOD	alcohol and other drug
ASCVD	atherosclerotic cardiovascular disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
ED	emergency department
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
MA	Medicare Advantage
MBISG	Medicare Bayesian Improved Surname Geocoding
NSAID	nonsteroidal anti-inflammatory drug
PDP	prescription drug plan

Figure 1. Disparities in Care by Race and Ethnicity: All Patient Experience Measures

Number of patient experience measures (out of 7) for which members of selected racial and ethnic groups had results that were above, similar to, or below the national average in 2023

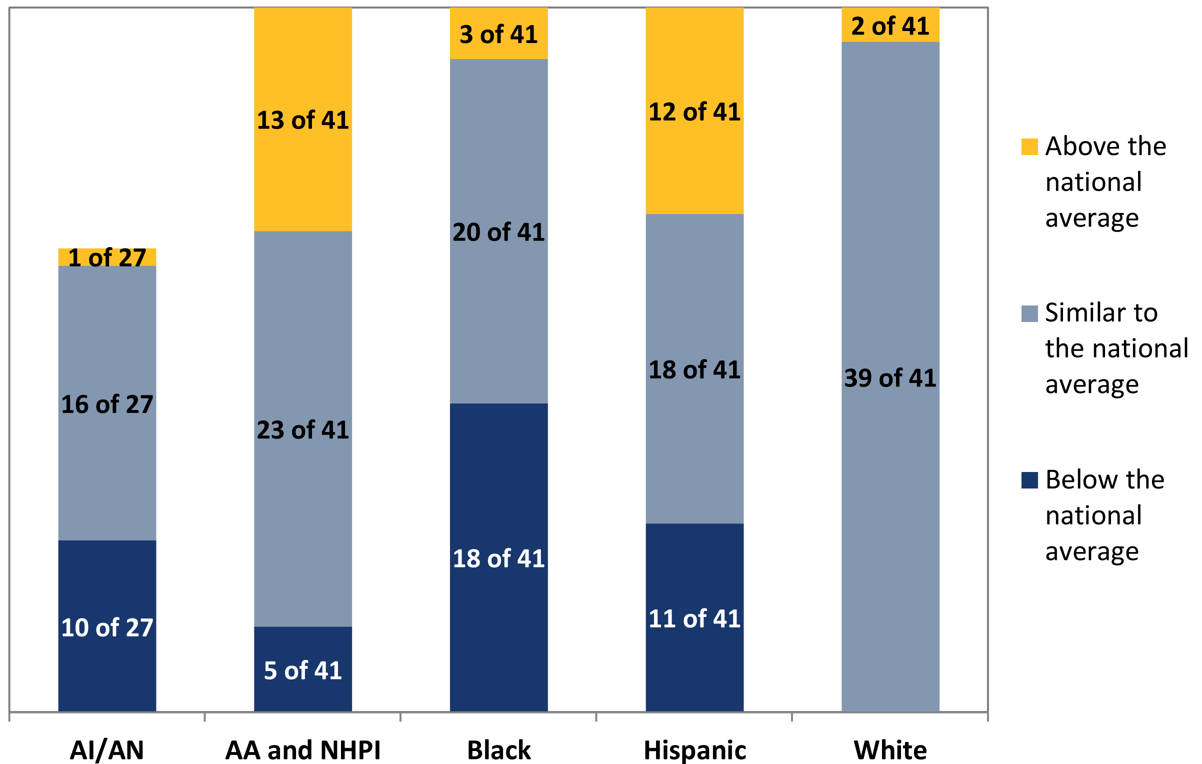


SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.

NOTE: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Figure 2. Disparities in Care by Race and Ethnicity: All Clinical Care Measures

Number of clinical care measures for which members of selected racial and ethnic groups had results that were above, similar to, or below the national average in Reporting Year 2023

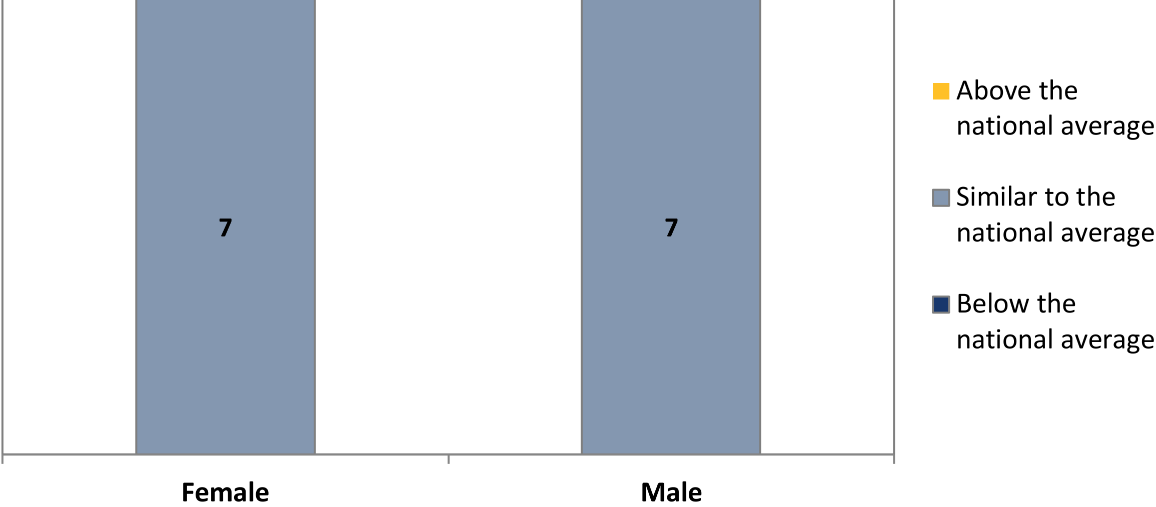


SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet the standards described on page 271. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Figure 3. Disparities in Care by Sex: All Patient Experience Measures

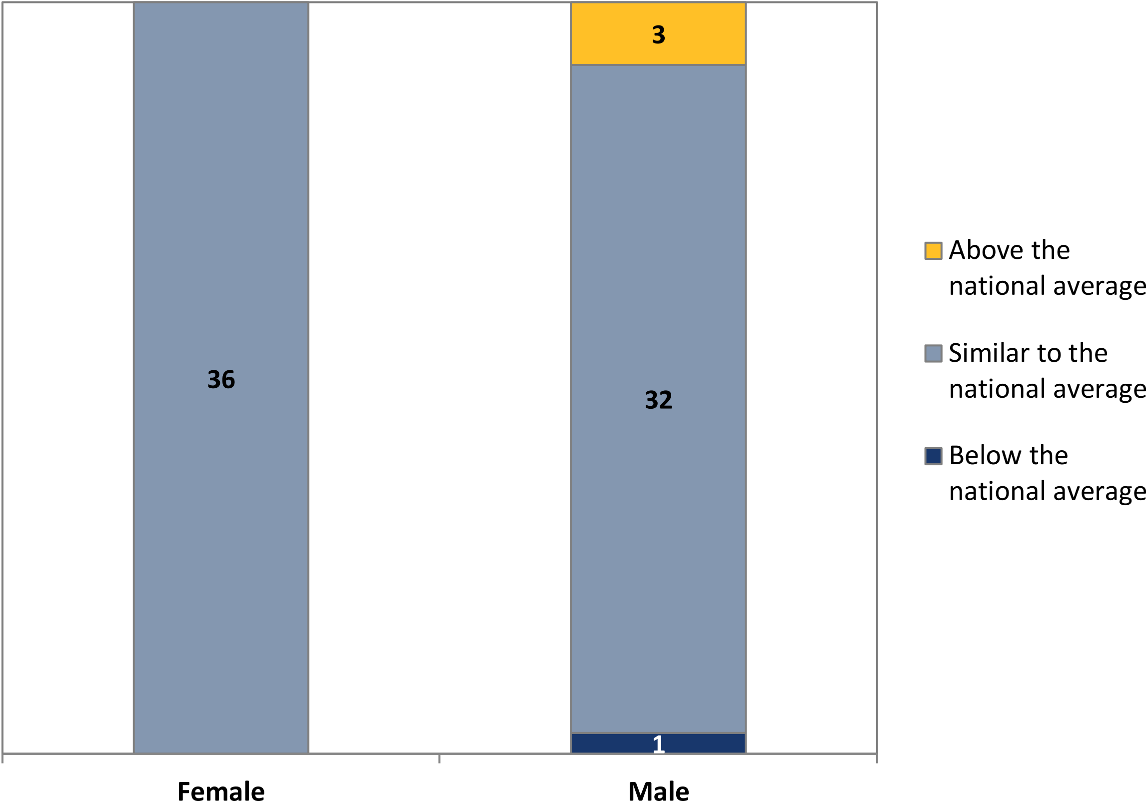
Number of patient experience measures (out of 7) for which female and male MA enrollees had results that were above, similar to, or below the national average in 2023



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.

Figure 4. Disparities in Care by Sex: All Clinical Care Measures

Number of clinical care measures (out of 36) for which female and male MA enrollees had results that were above, similar to, or below the national average in Reporting Year 2023

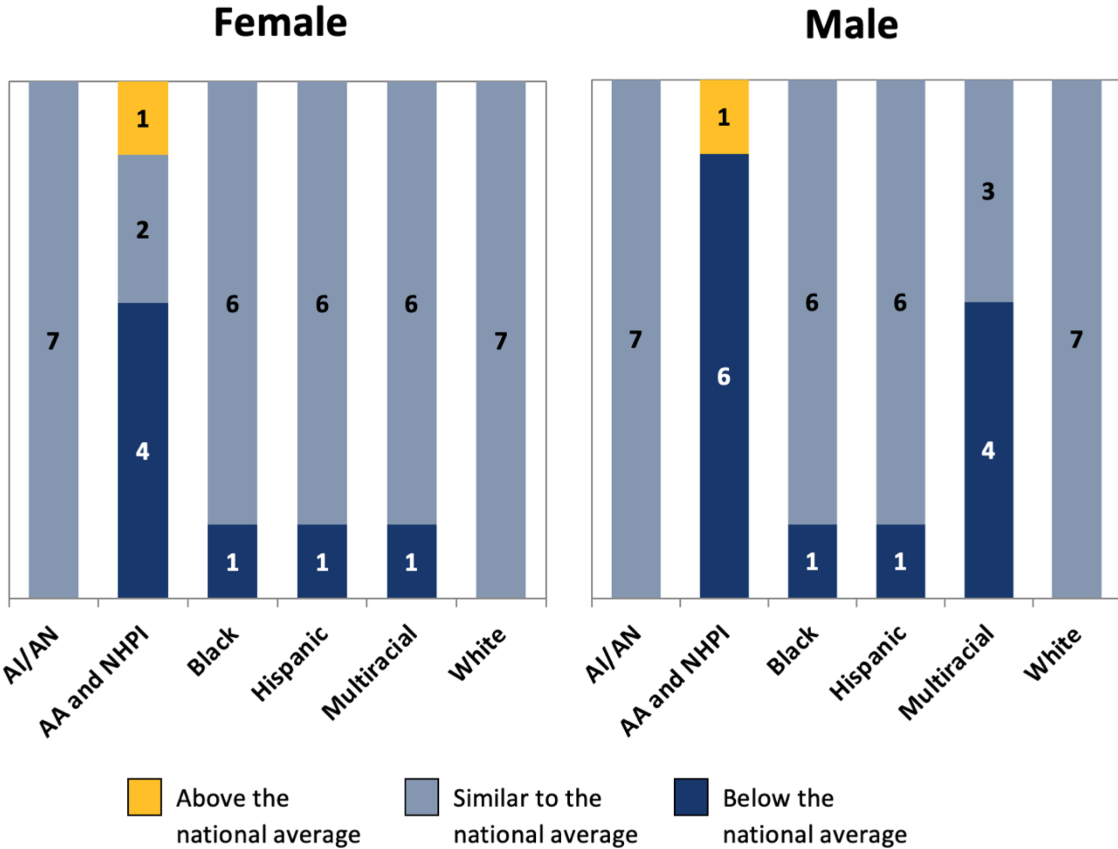


SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.

NOTES: When only two groups are compared, scores for the larger group—in most cases here, female MA enrollees—will always be closer to the overall (national) average than scores for the smaller group.

Figure 5. Racial and Ethnic Disparities in Care by Sex: All Patient Experience Measures

Number of patient experience measures (out of 7) for which female or male MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all female or male MA enrollees in 2023

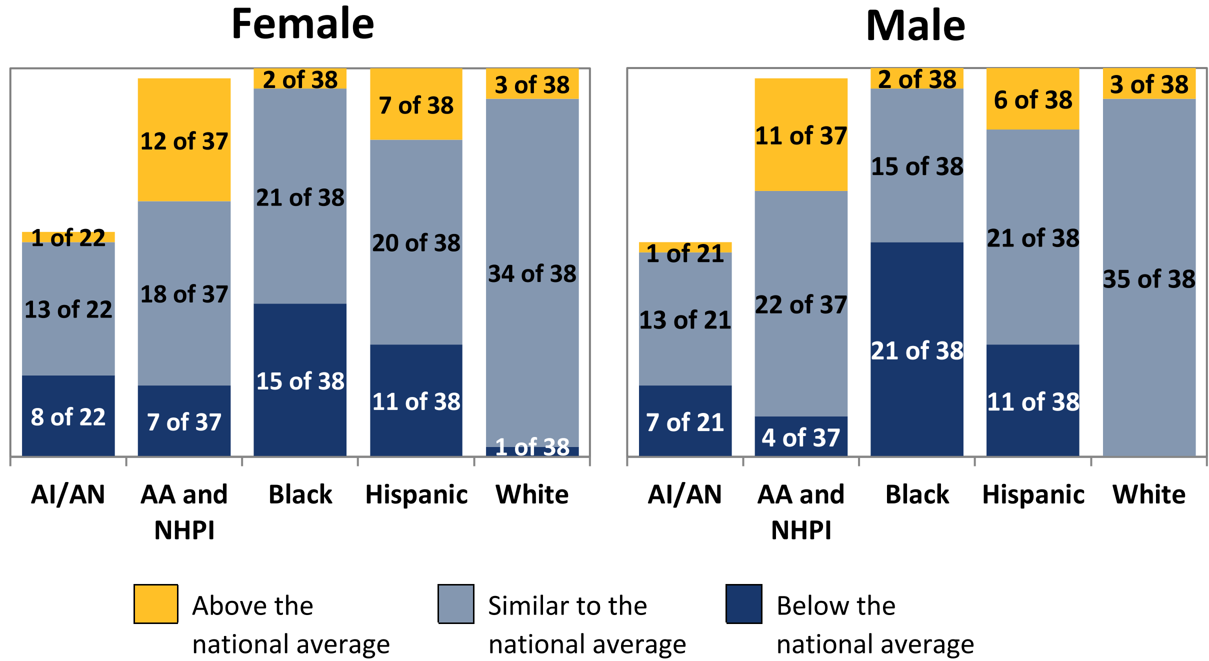


SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Figure 6. Racial and Ethnic Disparities in Care by Sex: All Clinical Care Measures

Number of clinical care measures for which female or male MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all female or male MA enrollees in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet the standards described on page 271. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Overview of Appendices

Appendix A: Disparities in Health Care in Medicare Advantage by Race and Ethnicity

Appendix A begins with a stacked bar chart showing the number of patient experience measures for which members of each racial and ethnic group reported experiences of care that were above, similar to, or below the national average. In this stacked bar chart, as in all stacked bar charts in this report, the focus is on practically significant differences (that is, differences that are statistically significant and exceed a magnitude threshold of 3 points). The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).[16] Following the stacked bar chart are separate, unstacked bar charts for each patient experience measure. These charts show the average scores (and associated 95-percent confidence intervals) for each racial and ethnic group on a 0–100 scale and indicate how each group's average score compares with the national average for all MA enrollees. Scores on patient experience measures represent the percentage of the best possible score for a measure. For example, consider a measure for which the best possible score is 4 and the worst possible score is 1. If a given group's score on that measure is 3.5, then that group's score on a 0–100 scale is $([3.5 - 1]/[4 - 1]) \times 100 = 83.3$. In the unstacked bar charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically and practically significant differences that are 3 points in magnitude or larger through the coloring of upward-and downward-facing arrows that appear in the bars.[17] Turquoise arrows indicate statistically significant differences that are less than 3 points in magnitude; dark blue arrows indicate statistically significant differences that are 3 points in magnitude or larger. After the patient experience measures, Appendix A presents a stacked bar chart showing the number of clinical care measures on which members of each racial and ethnic group scored above, similar to, or below the national average for all MA enrollees (again, focusing on practically significant differences). Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure that show the percentages (and associated 95-percent confidence intervals) of MA enrollees in each racial and ethnic group whose care met the standard called for by the specific measure (e.g., a test or treatment). In these unstacked bar charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically and practically significant differences that are 3 points in magnitude or larger through the coloring of upward-and downward-facing arrows that appear in the bars, as described above.

Appendix B: Disparities in Health Care in Medicare Advantage by Sex

Appendix B begins with a stacked bar chart showing the number of patient experience measures for which female and male MA enrollees reported experiences of care that were above, similar to, or below the national average for all MA enrollees. Following this stacked bar chart are separate, unstacked bar charts for each patient experience measure. After the patient experience measures, Appendix B presents a stacked bar chart showing the number of clinical care measures for which female and male MA enrollees scored above, similar to, or below the national average for all MA enrollees. Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure.

---

[16] The stacked bar charts that appear in Appendices A–C duplicate charts that appear in the main report. In the appendices, unlike in the main report, these stacked bar charts are followed directly by tables that detail the specific measures for each group represented in the figure that had scores that were 3 or more points above or below the relevant benchmark.

[17] In some cases, confidence intervals for group averages are very narrow and thus difficult to see on these charts. In those instances, these symbols denoting statistically significant differences can be relied on to tell whether the confidence interval crosses the national average line.

Appendix C: Disparities in Health Care in Medicare Advantage by Race and Ethnicity Within Sex

Appendix C begins with a pair of stacked bar charts that show the number of patient experience measures for which members of each racial and ethnic group reported experiences of care that were above, similar to, or below the national average for all MA enrollees separately for female and male MA enrollees. Following these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show, separately for female and male MA enrollees, the average score for each racial and ethnic group on a 0–100 scale. After the patient experience measures, Appendix C presents a pair of stacked bar charts that show the number of clinical care measures for which members of each racial and ethnic group scored above, similar to, or below the national average for all MA enrollees separately for female and male MA enrollees. Following these stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for female and male MA enrollees, the percentage of enrollees in each racial and ethnic group whose care met the standard called for by the specific measure.

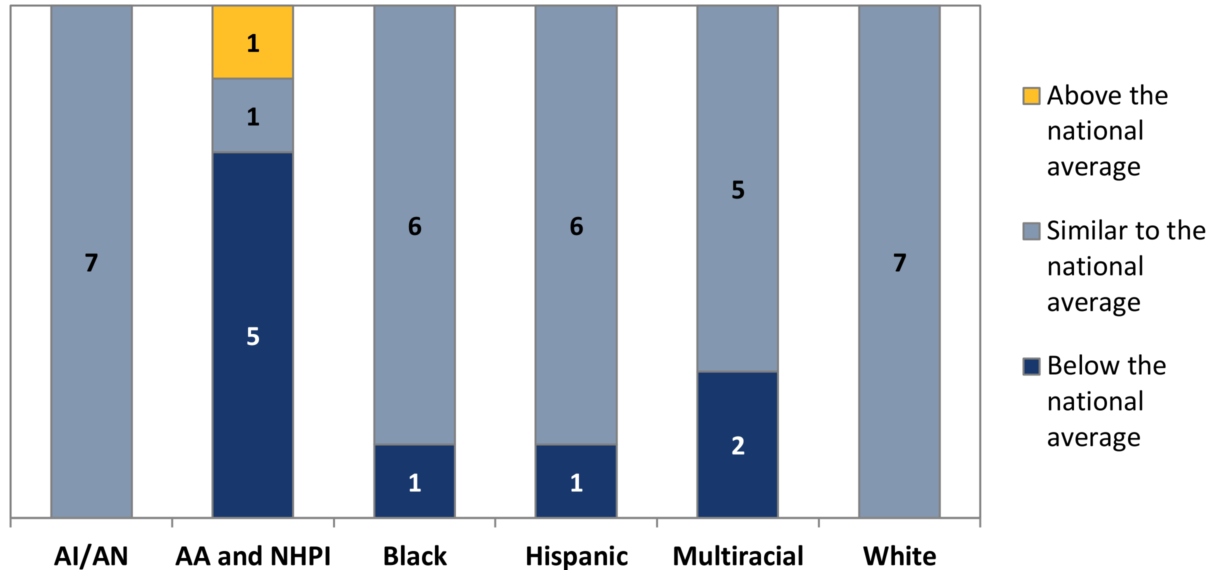
Appendix D: Data Sources and Methods

Appendix D contains detailed information on data sources and analytic methods.

Appendix A: Disparities in Health Care in Medicare Advantage by Race and Ethnicity

Disparities in Care by Race and Ethnicity: All Patient Experience Measures

Number of patient experience measures (out of 7) for which members of selected racial and ethnic groups had results that were above, similar to, or below the national average in 2023



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS survey.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Each racial or ethnic group is compared with the national average for all MA enrollees.

- **Above the national average** = The group reported experiences that were above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points† on a 0–100 scale.
- **Similar to the national average** = The group reported experiences that were similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group reported experiences that were below the national average. The difference is statistically significant and equal to or larger than 3 points† on a 0–100 scale.

† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

AA and NHPI MA enrollees had results that were below the national average

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Doctors Who Communicate Well
- Getting Needed Prescription Drugs

AA and NHPI MA enrollees had results that were above the national average

- Annual Flu Vaccine

Black MA enrollees had results that were below the national average

- Annual Flu Vaccine

Hispanic MA enrollees had results that were below the national average

- Getting Appointments and Care Quickly

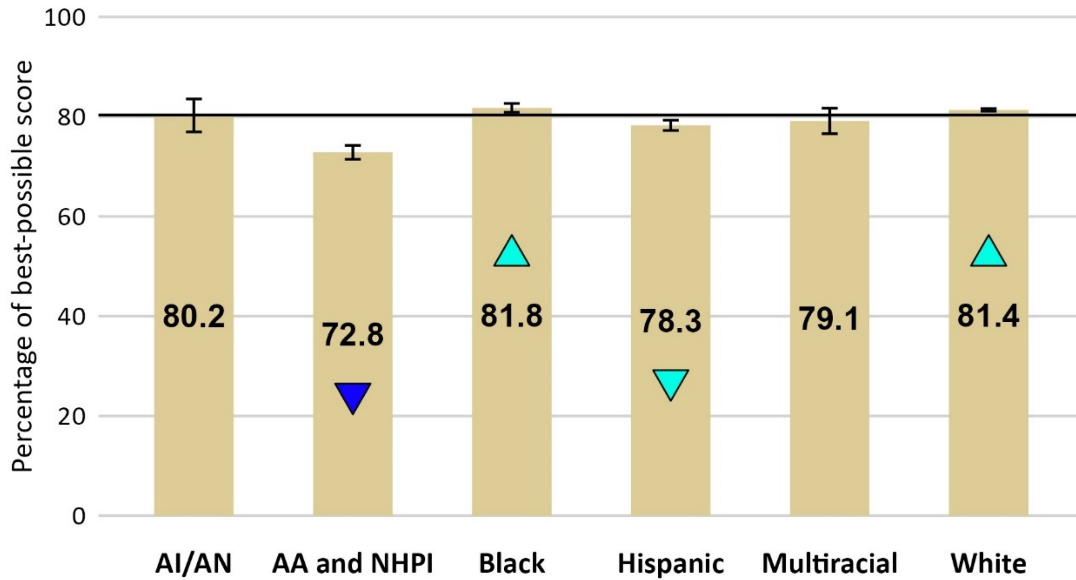
Multiracial MA enrollees had results that were below the national average

- Getting Needed Prescription Drugs
- Annual Flu Vaccine

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,† by race and ethnicity, 2023



— National average for all MA enrollees = 80.3

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

† This includes how often in the last six months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

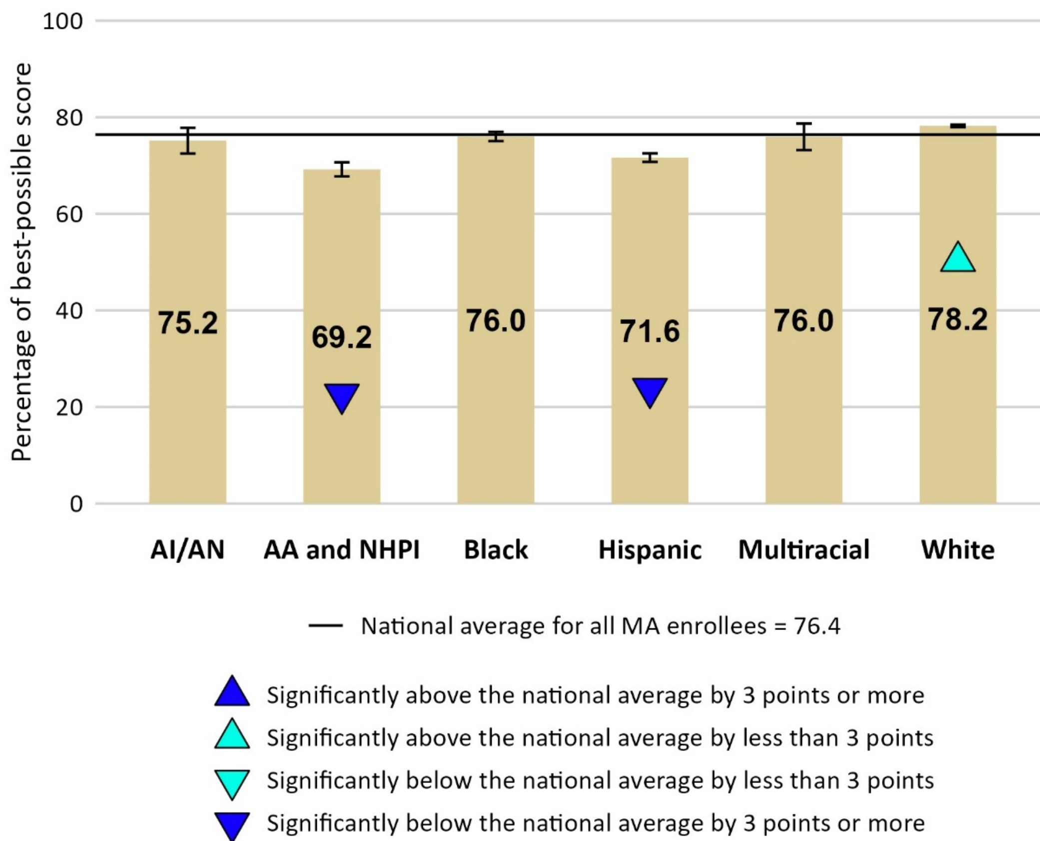
Disparities

- AI/AN MA enrollees reported experiences getting needed care that were **similar to** the national average for all MA enrollees.
- AA and NHPI MA enrollees reported experiences getting needed care that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences getting needed care that were **above**[‡] the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences getting needed care that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences getting needed care that were **similar to** the national average for all MA enrollees.
- White MA enrollees reported experiences getting needed care that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

[‡] Unlike on pp. 22–23, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

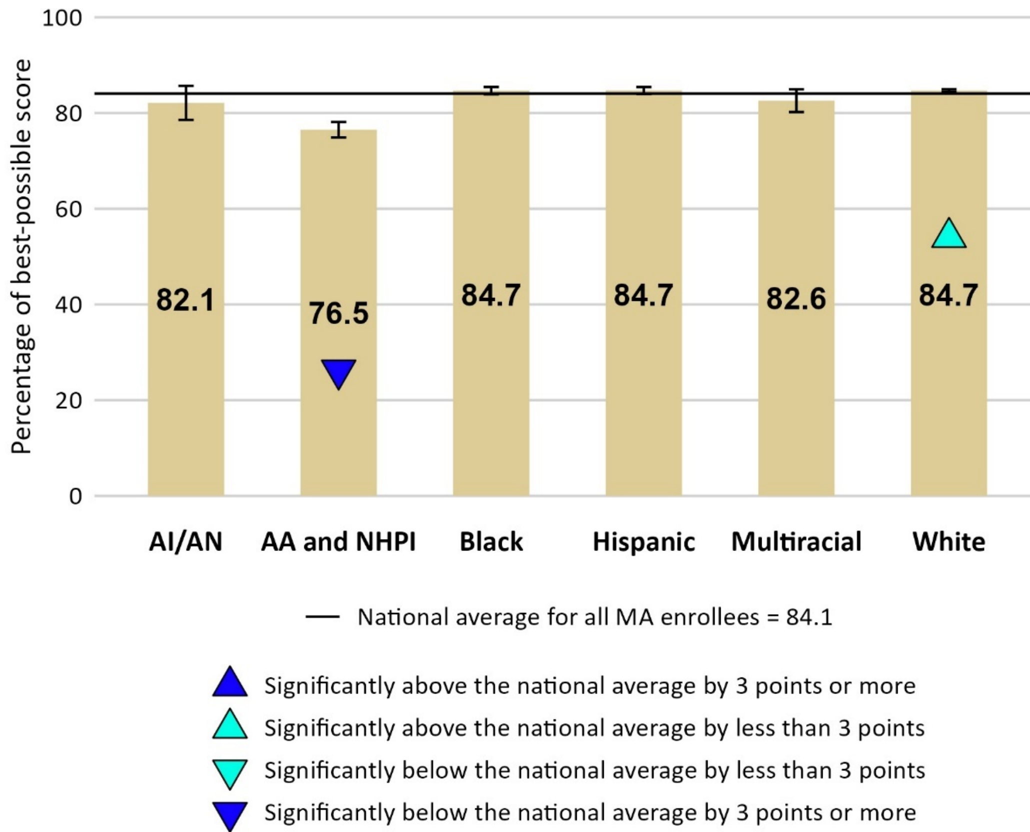
† This includes how often in the last six months patients got care that was needed right away, as well as how easy it was to get appointments for checkups and routine care.

Disparities

- AI/AN MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees.
- AA and NHPI MA enrollees reported experiences with getting appointments and care quickly that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees.
- Hispanic MA enrollees reported experiences with getting appointments and care quickly that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees.
- White MA enrollees reported experiences with getting appointments and care quickly that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,[†] by race and ethnicity, 2023



— National average for all MA enrollees = 84.1

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

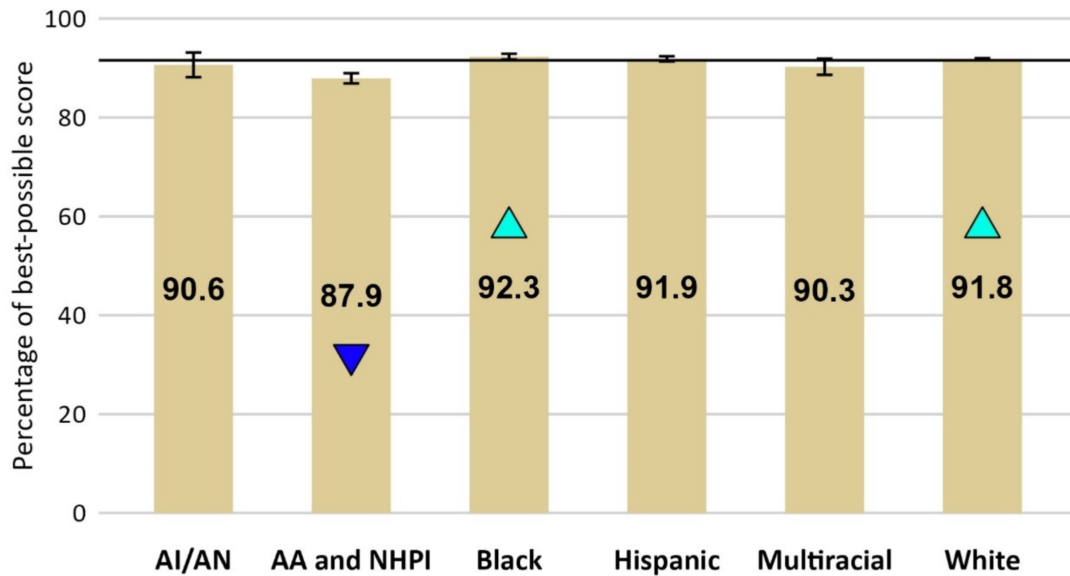
[†] This includes how often in the last six months health plan customer service staff provided the information or the help that plan members needed, how often plan members were treated with courtesy and respect, and how often forms from the health plan were easy to fill out.

Disparities

- AI/AN MA enrollees reported experiences with customer service that were **similar to** the national average for all MA enrollees.
- AA and NHPI MA enrollees reported experiences with customer service that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with customer service that were **similar to** the national average for all MA enrollees.
- Hispanic MA enrollees reported experiences with customer service that were **similar to** the national average for all MA enrollees.
- Multiracial MA enrollees reported experiences with customer service that were **similar to** the national average for all MA enrollees.
- White MA enrollees reported experiences with customer service that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by race and ethnicity, 2023



— National average for all MA enrollees = 91.6

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

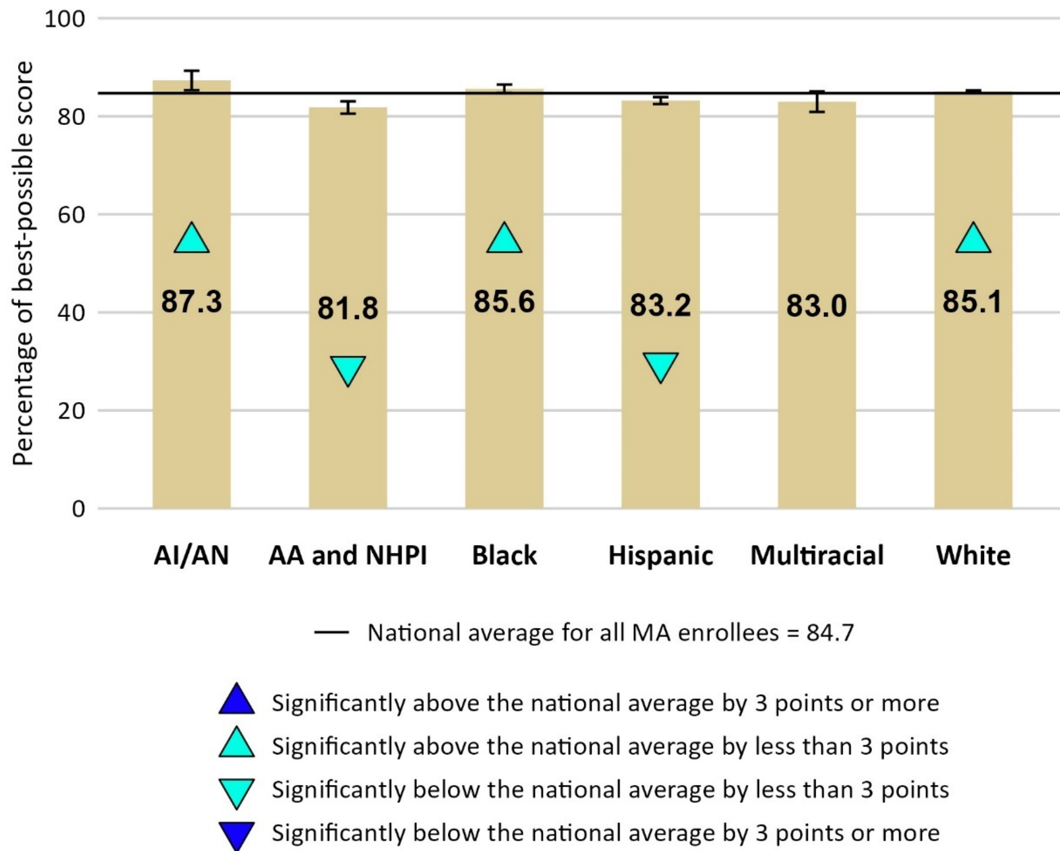
[†] This includes how often in the last six months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent enough time with patients.

Disparities

- AI/AN MA enrollees reported experiences with doctor communication that were **similar to** the national average for all MA enrollees.
- AA and NHPI MA enrollees reported experiences with doctor communication that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with doctor communication that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences with doctor communication that were **similar to** the national average for all MA enrollees.
- Multiracial MA enrollees reported experiences with doctor communication that were **similar to** the national average for all MA enrollees.
- White MA enrollees reported experiences with doctor communication that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,† by race and ethnicity, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

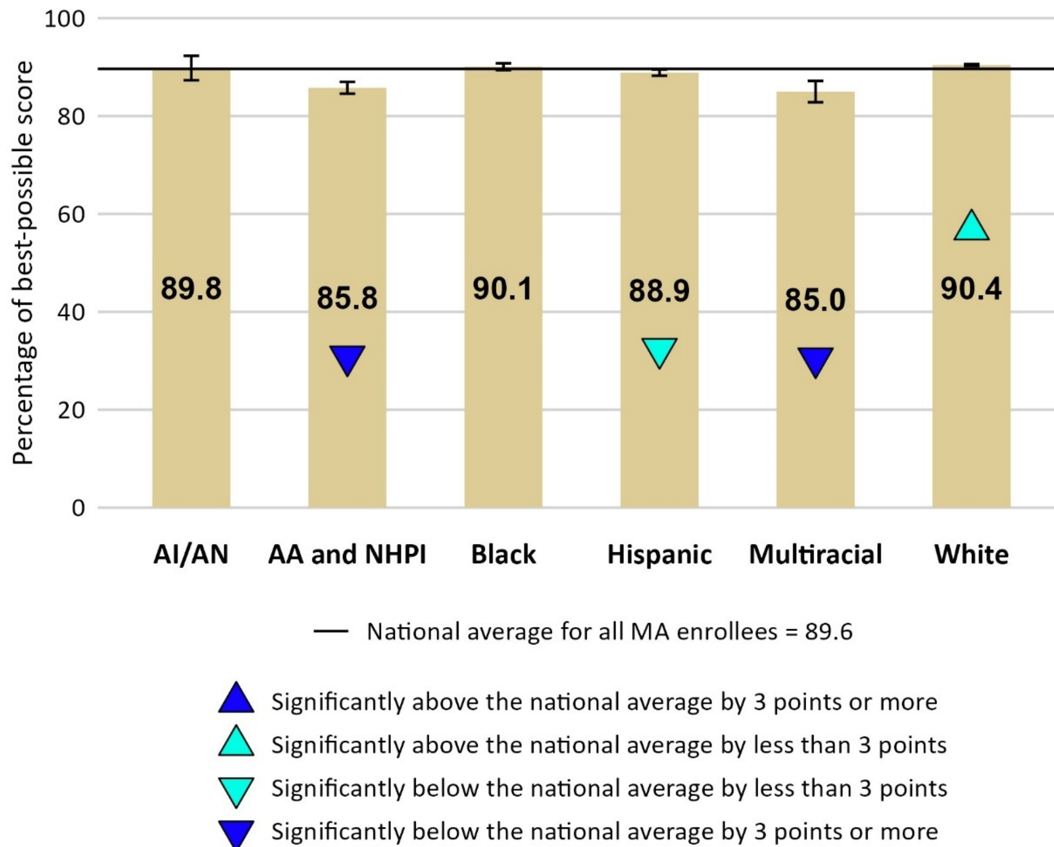
† This includes how often in the last six months doctors had medical records and other information about patients' care at patients' scheduled appointments and how quickly patients received their test results.

Disparities

- AI/AN MA enrollees reported experiences with care coordination that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- AA and NHPI MA enrollees reported experiences with care coordination that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with care coordination that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Hispanic MA enrollees reported experiences with care coordination that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences with care coordination that were **similar to** the national average for all MA enrollees.
- White MA enrollees reported experiences with care coordination that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plans,[†] by race and ethnicity, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

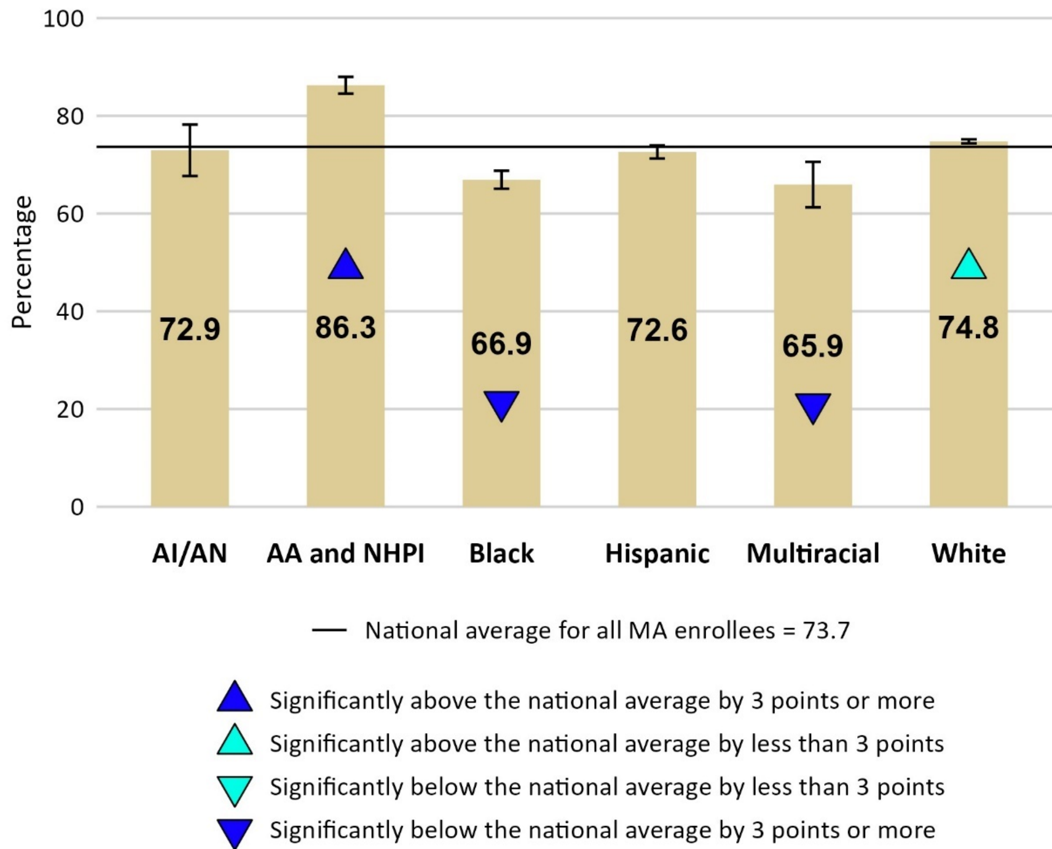
[†] This includes how often in the last six months it was easy to use the plan to get prescribed medications and how easy it was to fill prescriptions at a pharmacy or by mail.

Disparities

- AI/AN MA enrollees reported experiences with getting needed prescription drugs that were **similar to** the national average for all MA enrollees.
- AA and NHPI MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- Black MA enrollees reported experiences with getting needed prescription drugs that were **similar to** the national average for all MA enrollees.
- Hispanic MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Multiracial MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees by more than 3 points on a 0–100 scale.
- White MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by race and ethnicity, 2023



— National average for all MA enrollees = 73.7

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.

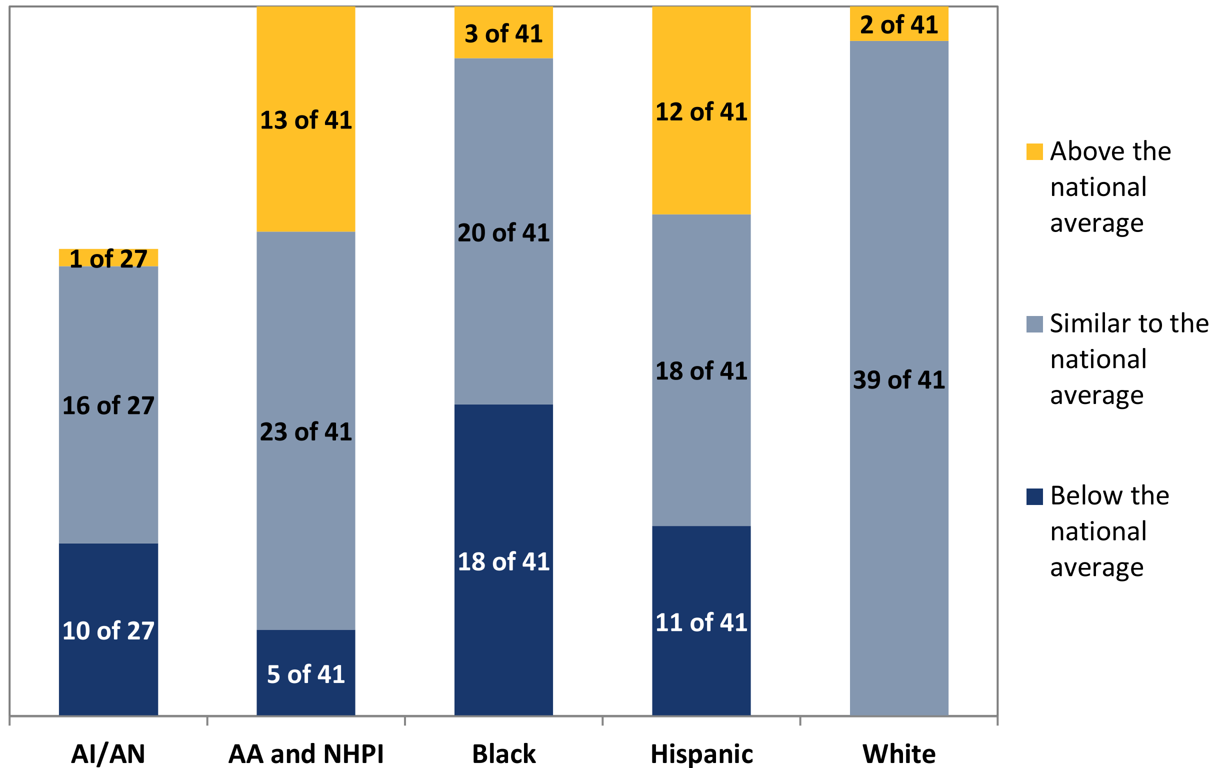
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Disparities

- The percentage of AI/AN MA enrollees who received the flu vaccine was **similar to** the national average for all MA enrollees.
- The percentage of AA and NHPI MA enrollees who received the flu vaccine was **above** the national average for all MA enrollees by more than 3 percentage points.
- The percentage of Black MA enrollees who received the flu vaccine was **below** the national average for all MA enrollees by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who received the flu vaccine was **similar to** the national average for all MA enrollees.
- The percentage of Multiracial MA enrollees who received the flu vaccine was **below** the national average for all MA enrollees by more than 3 percentage points.
- The percentage of White MA enrollees who received the flu vaccine was **above** the national average for all MA enrollees by less than 3 percentage points.

Disparities in Care by Race and Ethnicity: All Clinical Care Measures

Number of clinical care measures for which members of selected racial and ethnic groups had results that were above, similar to, or below the national average in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet standards described on page 271. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Each racial or ethnic group is compared with the national average for all MA enrollees.

- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points[†] on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group received care that was below the national average. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

[†] A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

AI/AN MA enrollees had results that were below the national average

- Breast Cancer Screening
- Testing to Confirm COPD
- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Screening in Older Women
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment

AI/AN MA enrollees had results that were above the national average

- Initiation of AOD Dependence Treatment

AA and NHPI MA enrollees had results that were below the national average

- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment

AA and NHPI MA enrollees had results that were above the national average

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Statin Use in Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Management in Women Who Had a Fracture
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls
- Avoiding Use of High Risk Medications in Older Adults
- Avoiding Use of Opioids at High Dosage

Black MA enrollees had results that were below the national average

- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Osteoporosis Screening in Older Women
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Medication Reconciliation After Inpatient Discharge

Black MA enrollees had results that were better than the national average

- Breast Cancer Screening
- Initiation of AOD Dependence Treatment
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Hispanic MA enrollees had results that were below the national average

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Hispanic MA enrollees had results that were above the national average

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Statin Use in Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Osteoporosis Screening in Older Women
- Osteoporosis Management in Women Who Had a Fracture
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Pharmacotherapy for Opioid Use Disorder

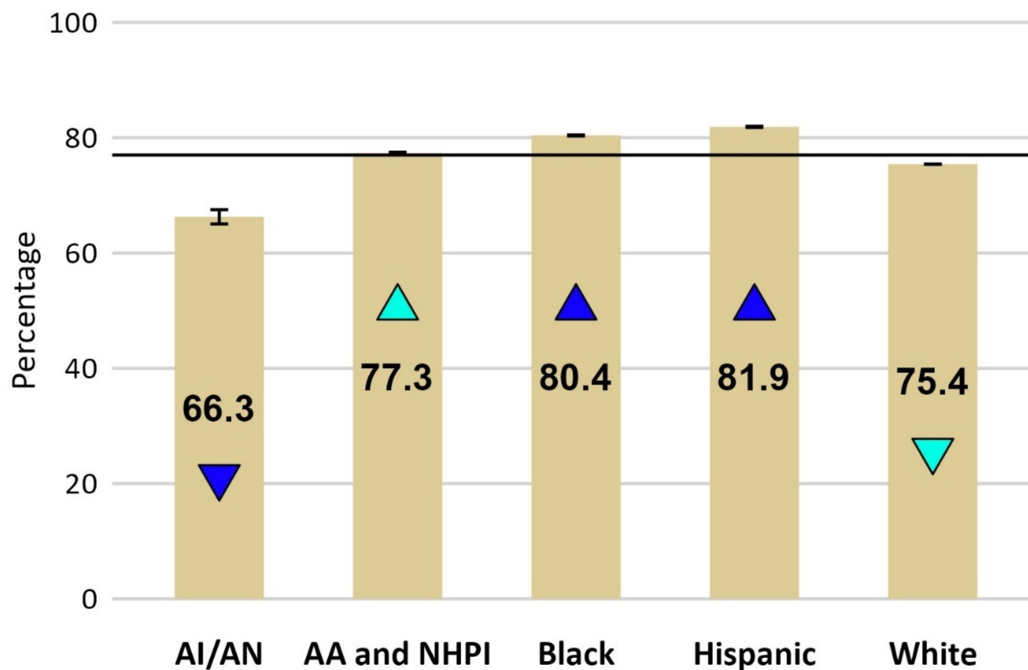
White MA enrollees had results that were above the national average

- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Clinical Care: Prevention and Screening

Breast Cancer Screening

Percentage of female MA enrollees aged 50 to 74 years who had appropriate screening for breast cancer, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 77.0

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

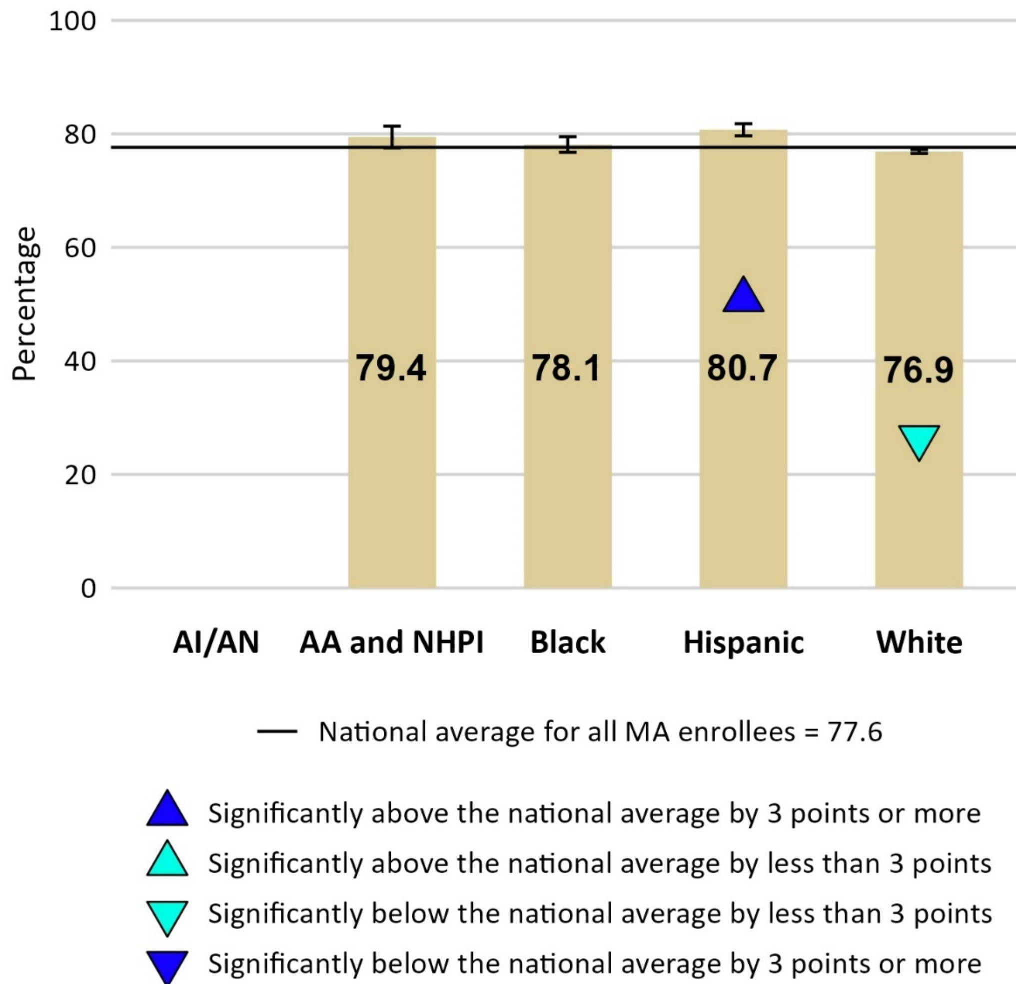
- The percentage of eligible[†] female AI/AN MA enrollees who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female AA and NHPI MA enrollees who were appropriately screened for breast cancer was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.[‡]
- The percentage of eligible female Black MA enrollees who were appropriately screened for breast cancer was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female Hispanic MA enrollees who were appropriately screened for breast cancer was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female White MA enrollees who were appropriately screened for breast cancer was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.

[†] In discussing clinical care measures that have criteria for being included in the denominator of the measure, *eligible* is sometimes used to refer to people who meet the inclusion criteria (which are specified in the chart subtitle).

[‡] Unlike on pp. 39–41, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

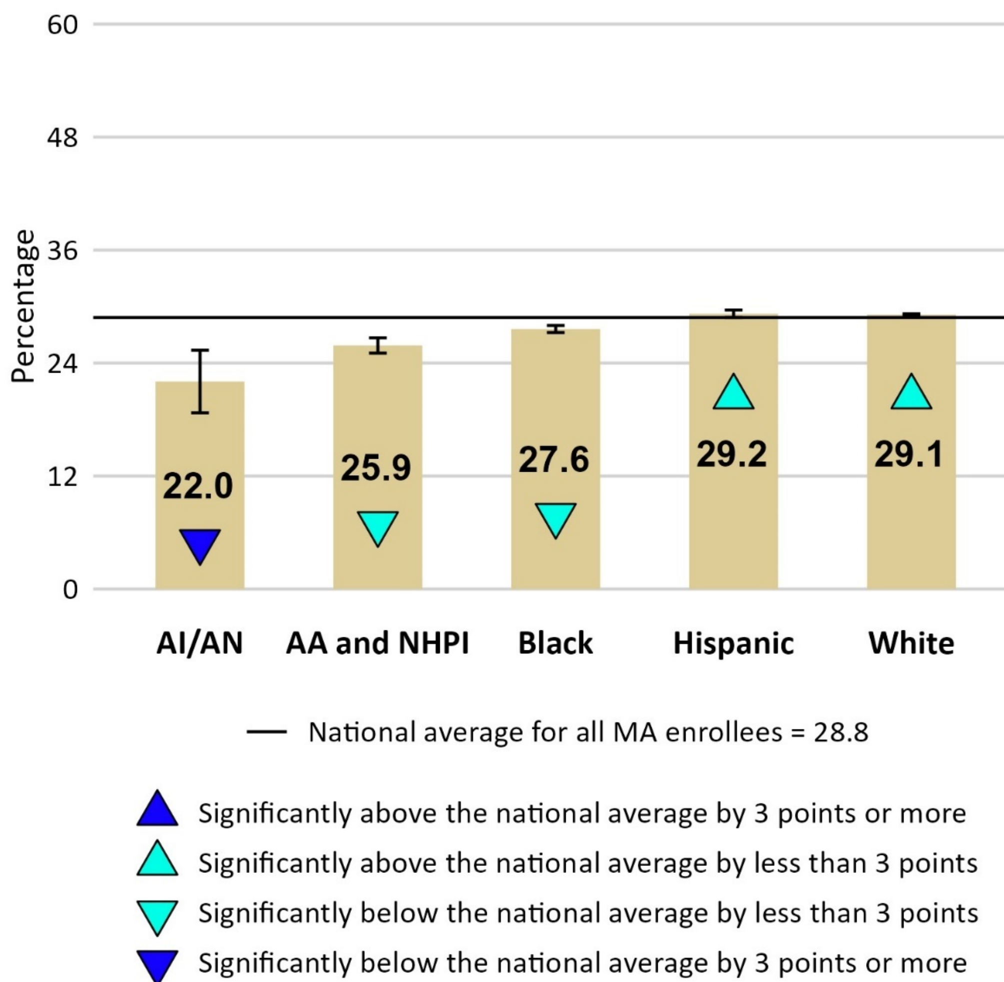
Disparities

- The percentage of eligible AA and NHPI MA enrollees who were appropriately screened for colorectal cancer was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible Black MA enrollees who were appropriately screened for colorectal cancer was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible Hispanic MA enrollees who were appropriately screened for colorectal cancer was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible White MA enrollees who were appropriately screened for colorectal cancer screening was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by race and ethnicity, Reporting Year 2023



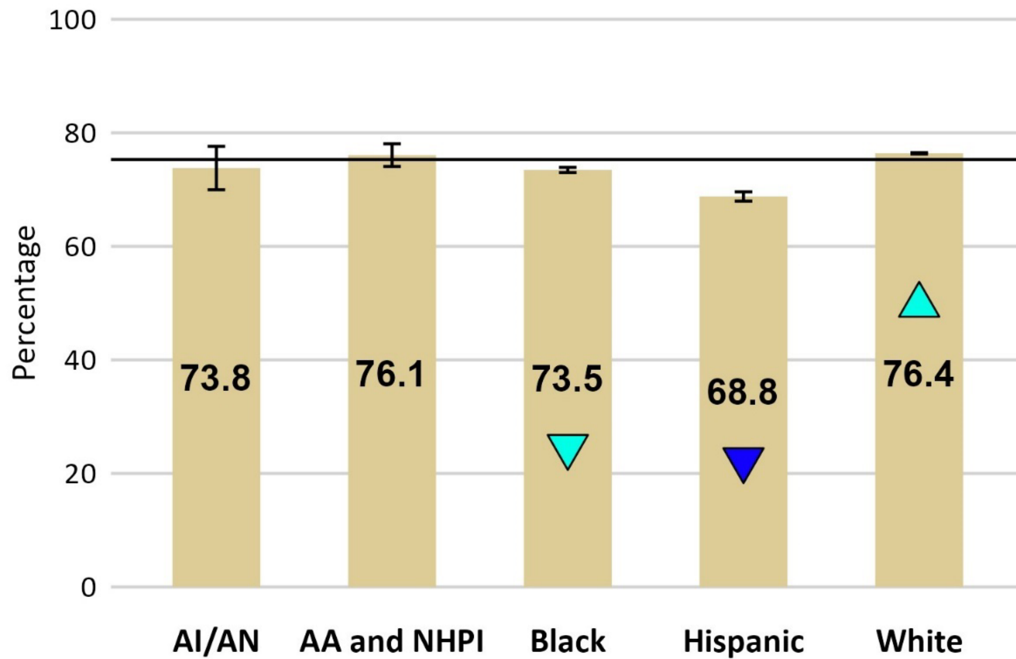
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of eligible AI/AN MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible AA and NHPI MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible Black MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible White MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 75.3

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

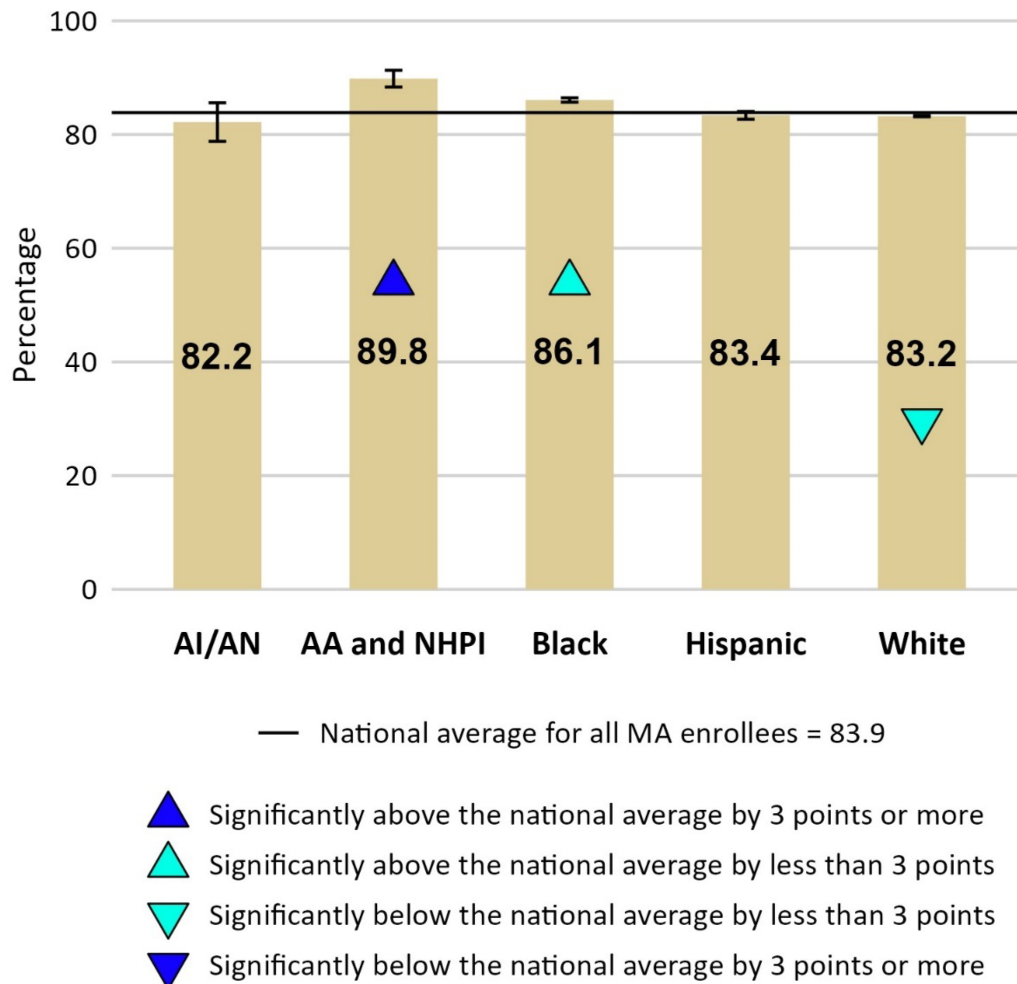
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of eligible AI/AN MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible AA and NHPI MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible Black MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible White MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

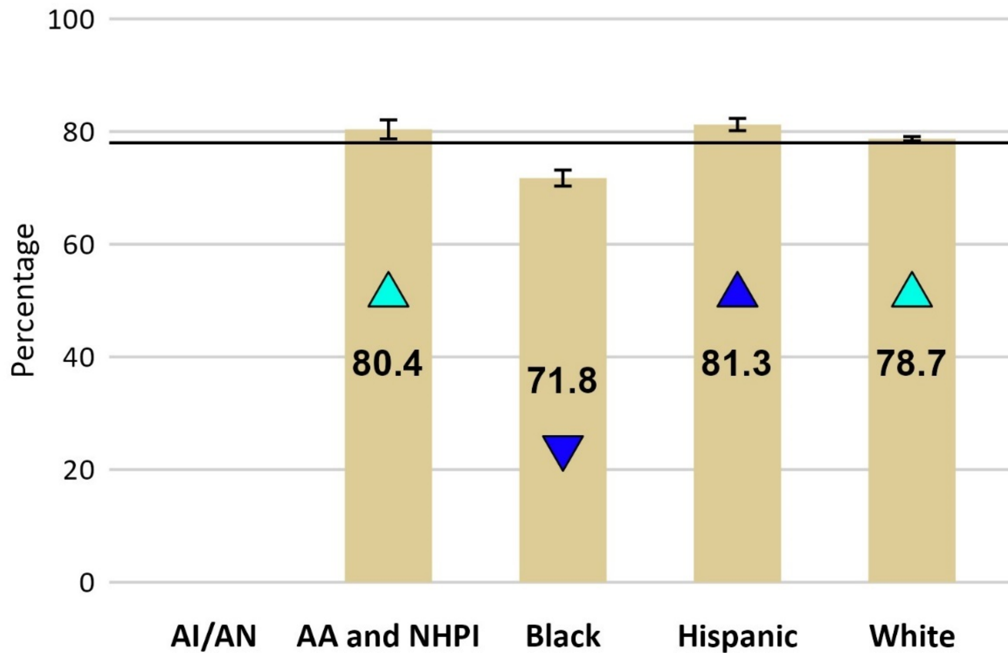
Disparities

- The percentage of eligible AI/AN MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible AA and NHPI MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible Black MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible White MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled[†] during the past year, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 78.0

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

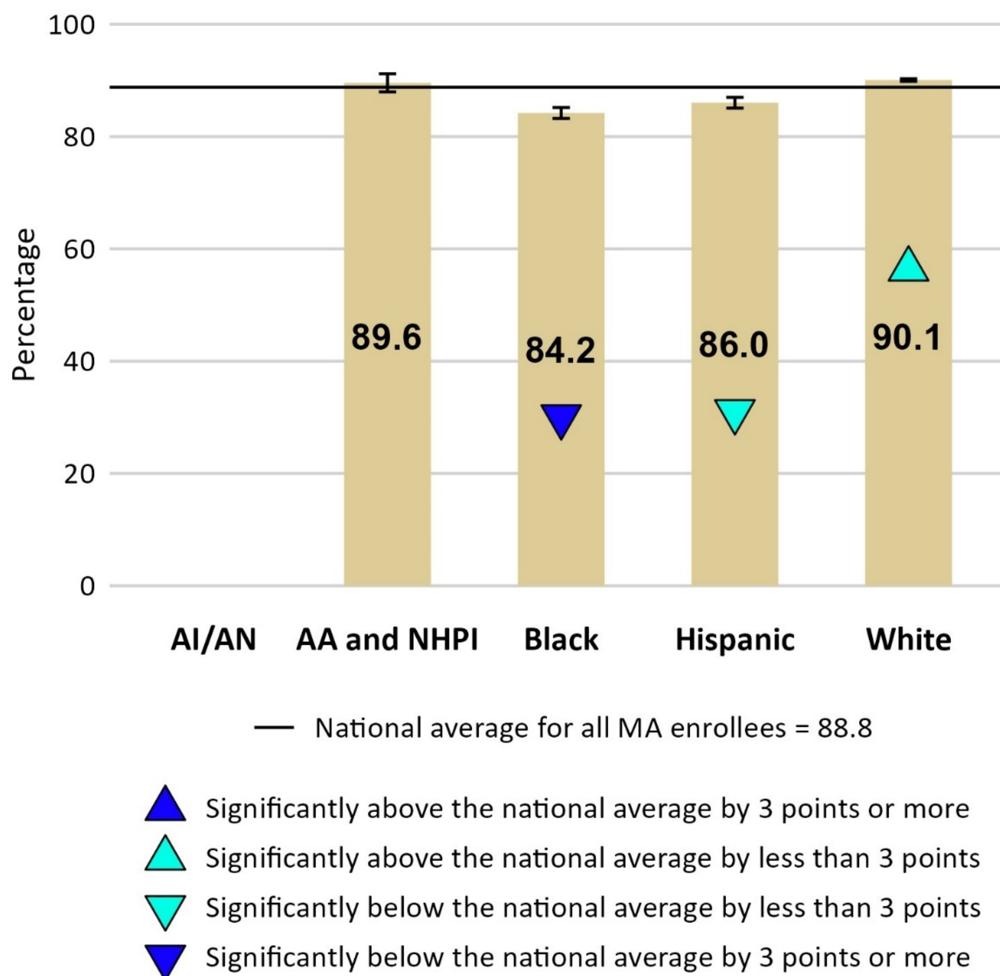
[†] Less than 140/90 for patients 18 to 59 years of age and for patients 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for patients 60 to 85 years of age without a diagnosis of diabetes.

Disparities

- The percentage of eligible AA and NHPI MA enrollees who had their blood pressure adequately controlled was **above** the national average for all eligible MA enrollees by less than 3 percentage point.
- The percentage of eligible Black MA enrollees who had their blood pressure adequately controlled was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who had their blood pressure adequately controlled was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible White MA enrollees who had their blood pressure adequately controlled was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI) who received continuous beta-blocker treatment for six months after discharge, by race and ethnicity, Reporting Year 2023



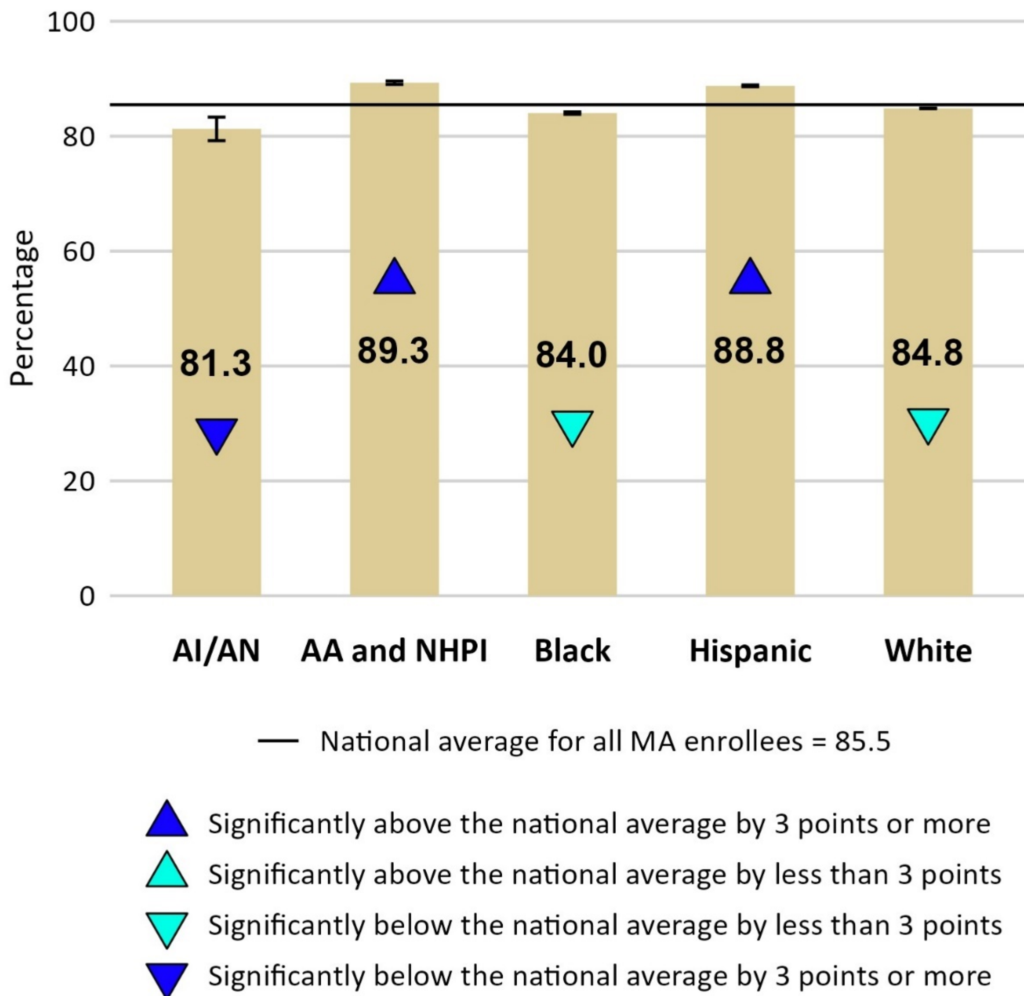
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of eligible AA and NHPI MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible Black MA enrollees who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who received continuous beta-blocker treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible White MA enrollees who received continuous beta-blocker treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 85.5

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

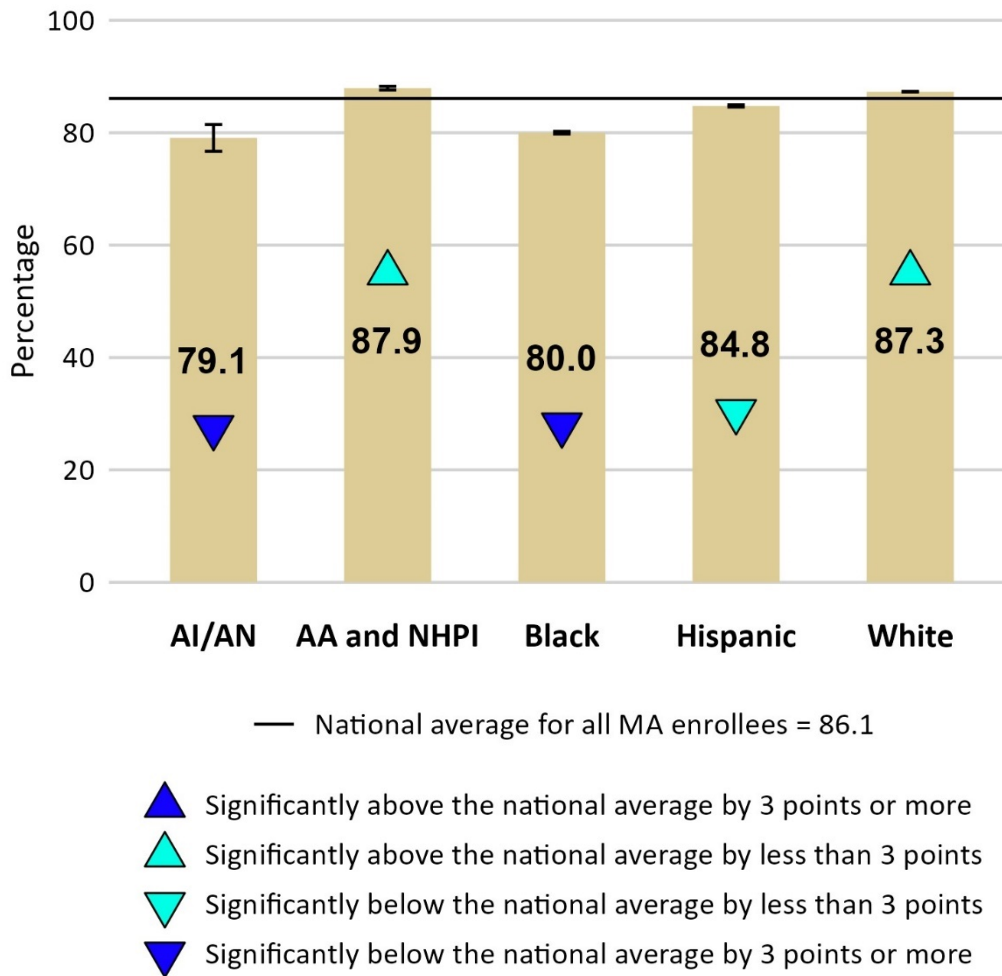
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all MA enrollees with clinical ASCVD by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with clinical ASCVD who received statin therapy was **above** the national average for all MA enrollees with clinical ASCVD by more than 3 percentage points.
- The percentage of Black MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with clinical ASCVD who received statin therapy was **above** the national average for all MA enrollees with clinical ASCVD by more than 3 percentage points.
- The percentage of White MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.

Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication and remained on the medication for at least 80 percent of the treatment period, by race and ethnicity, Reporting Year 2023



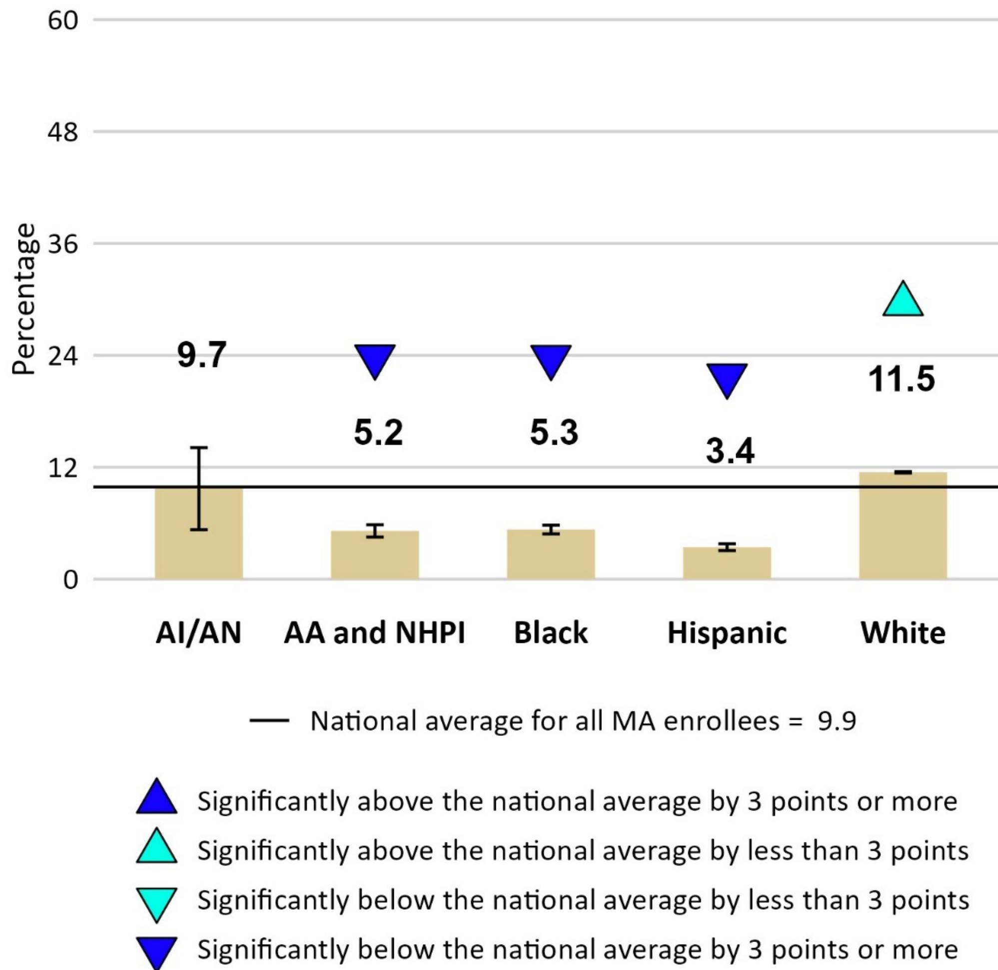
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all MA enrollees with clinical ASCVD by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with clinical ASCVD who had proper statin medication adherence was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of Black MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all MA enrollees with clinical ASCVD by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of White MA enrollees with clinical ASCVD who had proper statin medication adherence was **above** the national average for all MA enrollees with clinical ASCVD by less than 3 percentage points.

Initiation of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older† who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

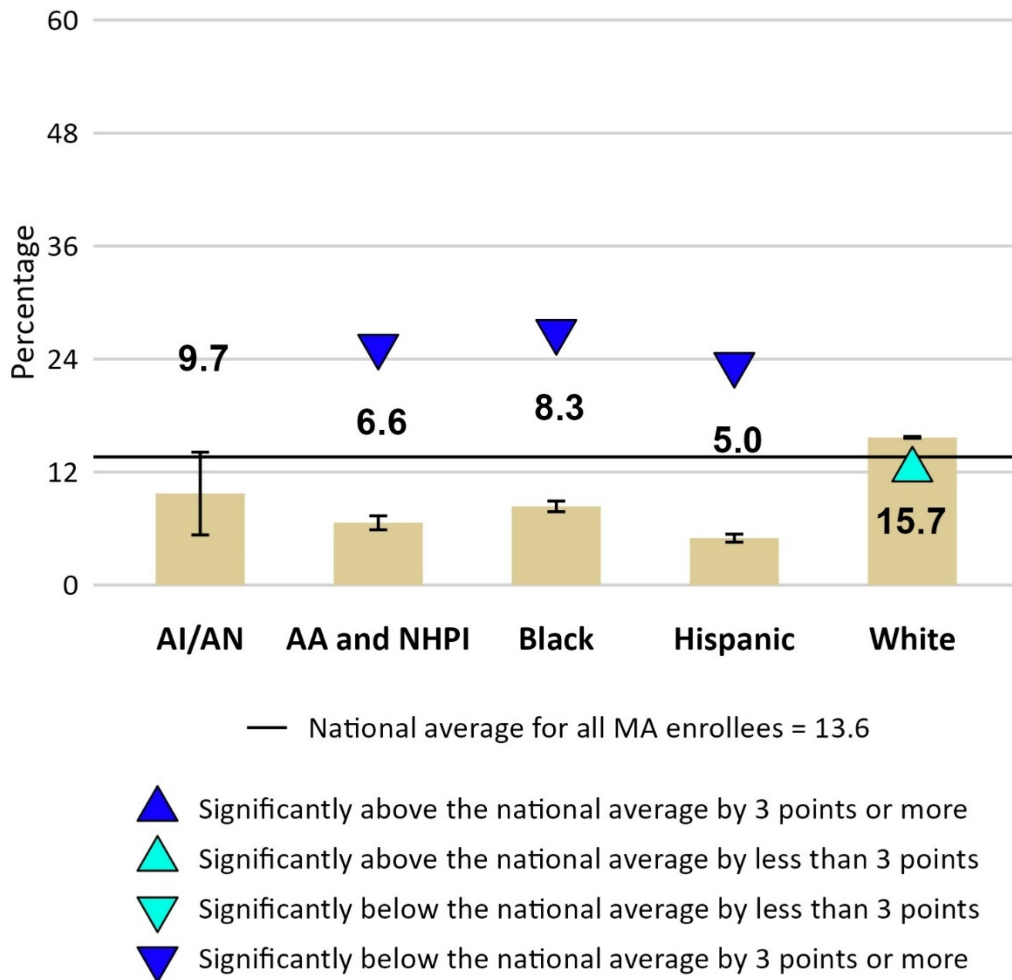
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of AI/AN MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **similar to** the national average for all MA enrollees who had a cardiac event.
- The percentage of AA and NHPI MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by more than 3 percentage points.
- The percentage of Black MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by more than 3 percentage points.
- The percentage of White MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

Engagement of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older† who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

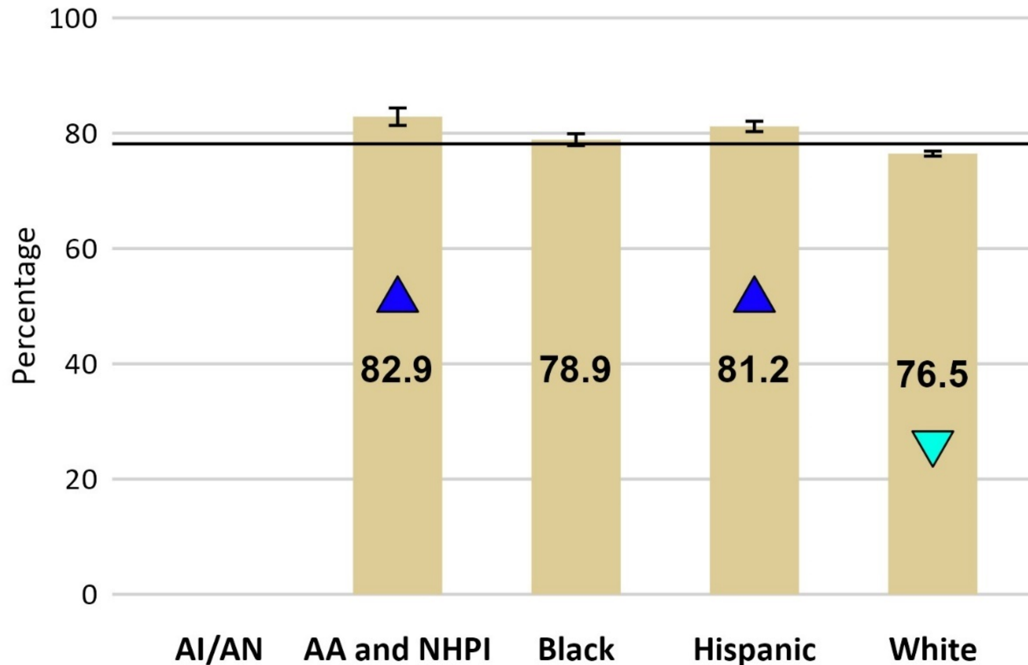
Disparities

- The percentage of AI/AN MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **similar to** the national average for all MA enrollees who had a cardiac event.
- The percentage of AA and NHPI MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by more than 3 percentage points.
- The percentage of Black MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by more than 3 percentage points.
- The percentage of White MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

Clinical Care: Diabetes

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 78.2

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

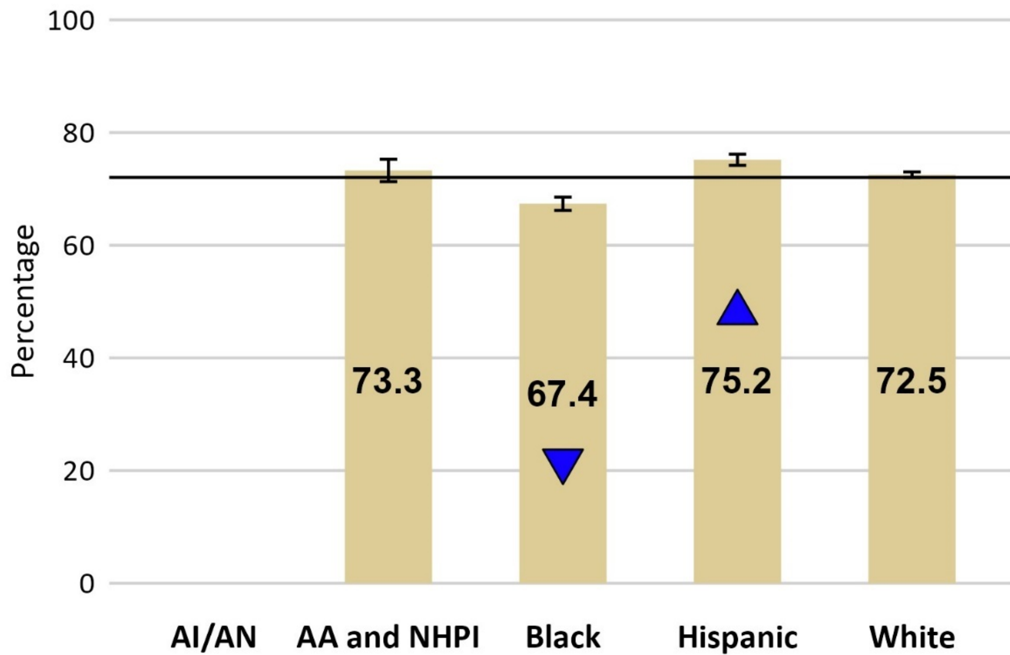
Disparities

- The percentage of AA and NHPI MA enrollees with diabetes who had an eye exam in the past year was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had an eye exam in the past year was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of Hispanic MA enrollees with diabetes who had an eye exam in the past year was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.[†]
- The percentage of White MA enrollees with diabetes who had an eye exam in the past year was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

[†] Prior to rounding

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 72.1

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

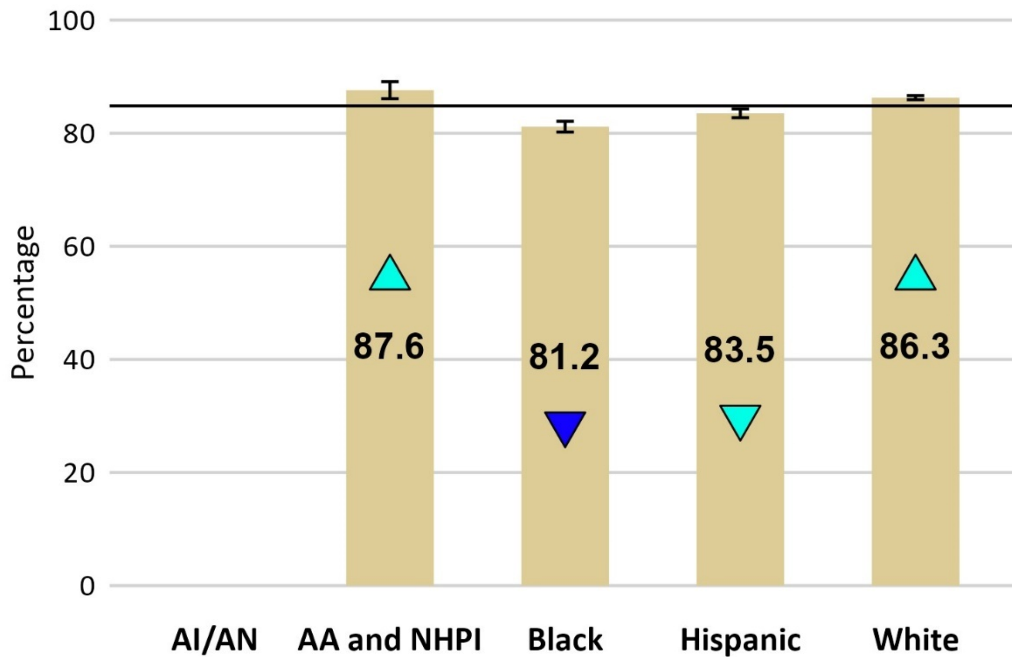
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees with diabetes who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes.
- The percentage of Black MA enrollees with diabetes who had their blood pressure under control was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who had their blood pressure under control was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had their blood pressure under control was **similar to** the national average for all MA enrollees with diabetes.

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or lower, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 84.8

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

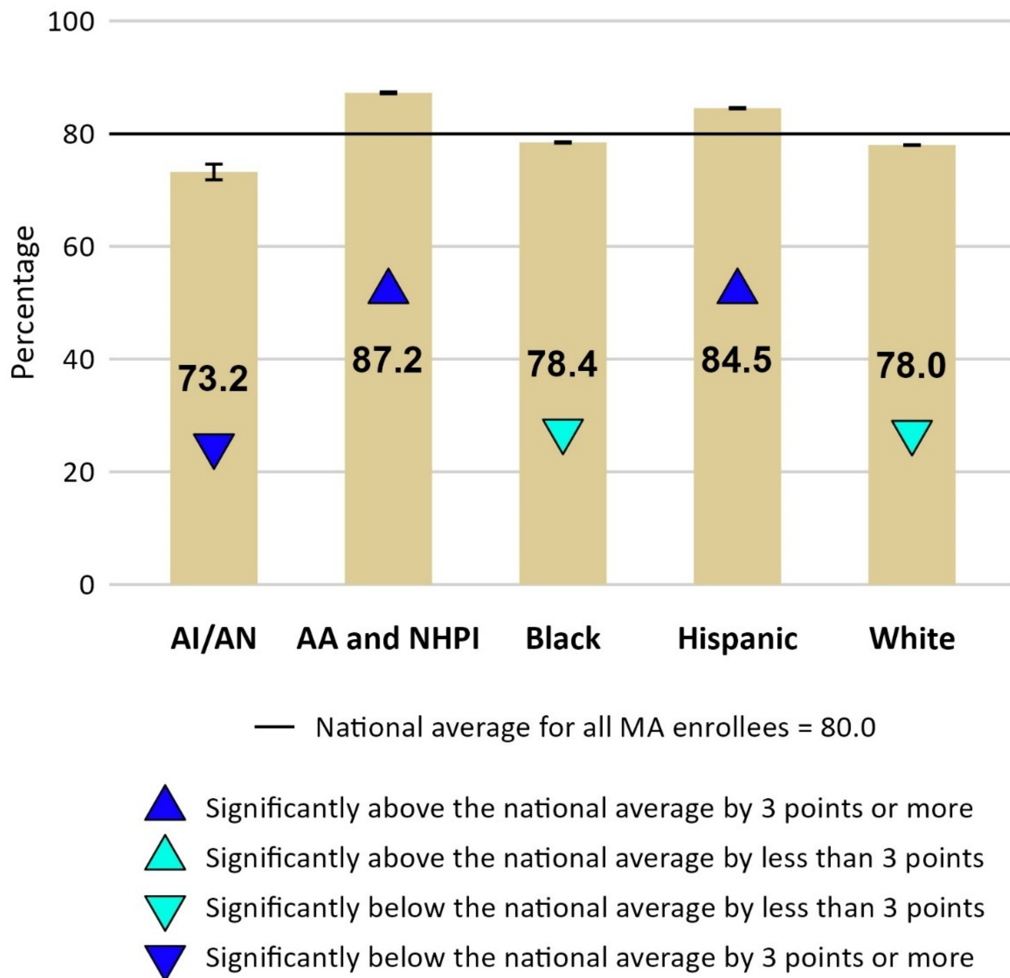
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of AA and NHPI MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who received statin therapy, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

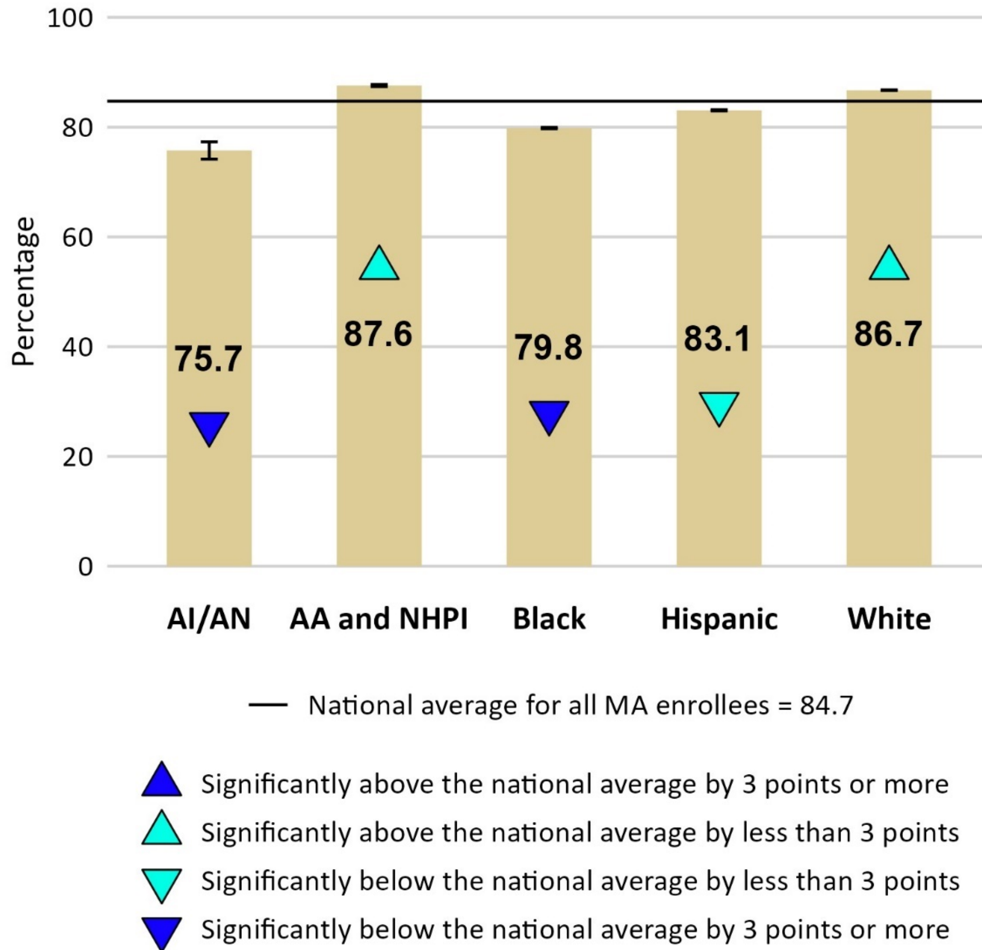
† This excludes enrollees who also have clinical ASCVD.

Disparities

- The percentage of AI/AN MA enrollees with diabetes who received statin therapy was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with diabetes who received statin therapy was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who received statin therapy was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who received statin therapy was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of White MA enrollees with diabetes who received statin therapy was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who were dispensed a statin medication and remained on the medication for at least 80 percent of the treatment period, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

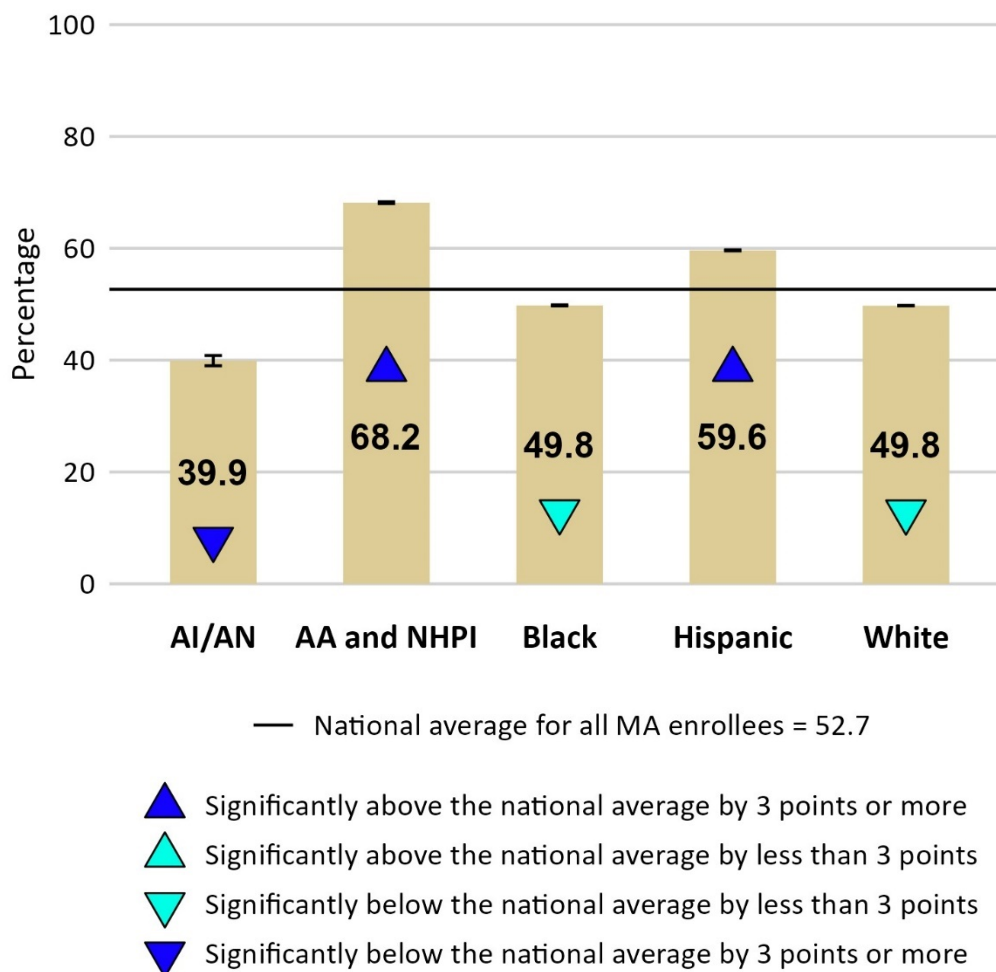
[†] This excludes enrollees who also have clinical ASCVD.

Disparities

- The percentage of AI/AN MA enrollees with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with diabetes who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of White MA enrollees with diabetes who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Kidney Health Evaluation for Patients with Diabetes

Percentage of MA enrollees aged 18 to 85 years with diabetes (type 1 and type 2) who received an annual kidney health evaluation,[†] by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

[†] Includes both an estimated glomerular filtration rate and a urine albumin-creatinine ratio.

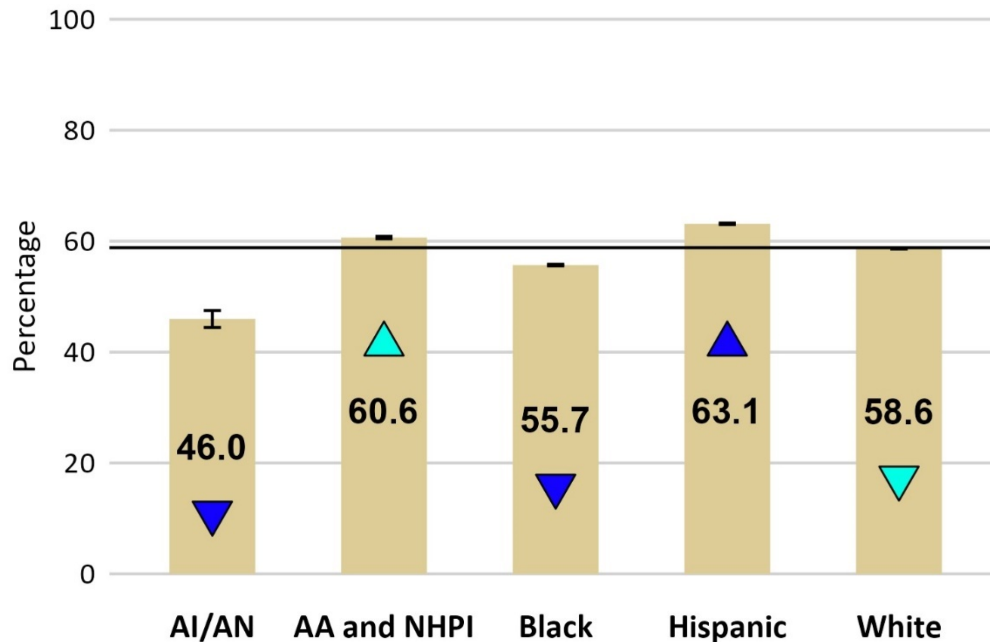
Disparities

- The percentage of AI/AN MA enrollees with diabetes who received an annual kidney health evaluation was **below** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with diabetes who received an annual kidney health evaluation was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of Black MA enrollees with diabetes who received an annual kidney health evaluation was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with diabetes who received an annual kidney health evaluation was **above** the national average for all MA enrollees with diabetes by more than 3 percentage points.
- The percentage of White MA enrollees with diabetes who received an annual kidney health evaluation was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Clinical Care: Musculoskeletal Conditions

Osteoporosis Screening in Older Women

Percentage of female MA enrollees aged 65 to 75 years who had appropriate screening for osteoporosis, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 58.8

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

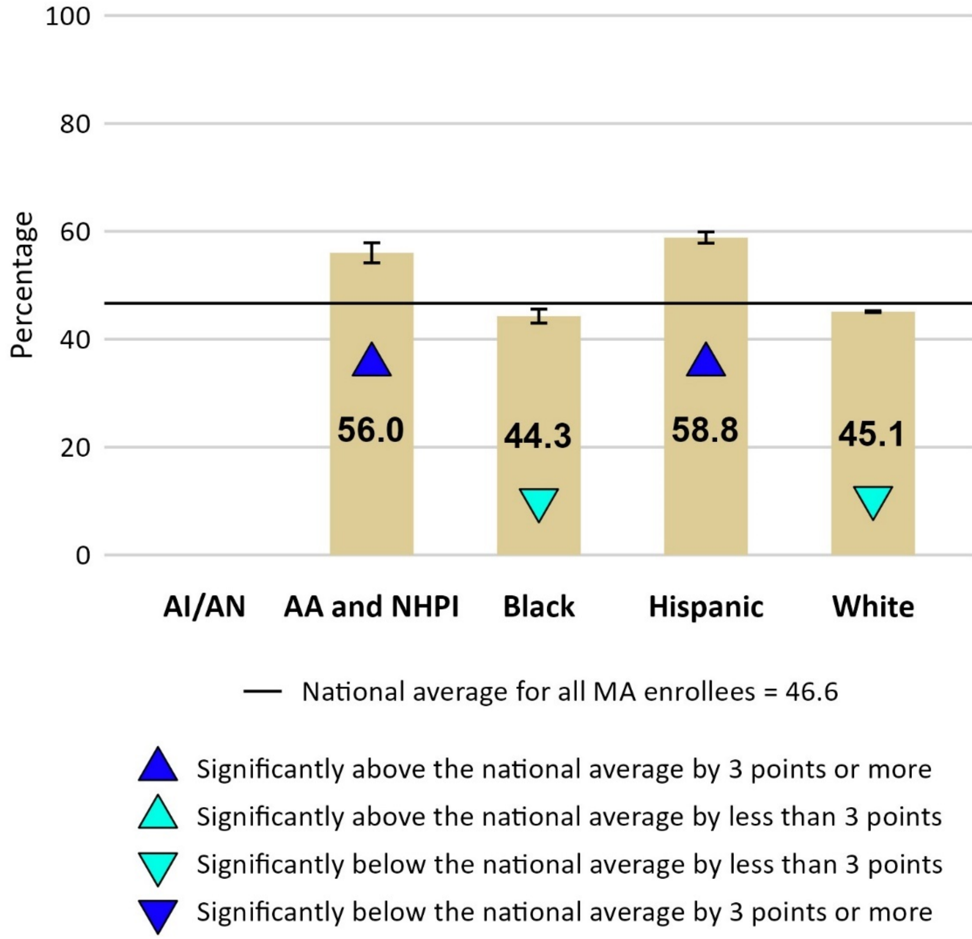
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of eligible female AI/AN MA enrollees who were appropriately screened for osteoporosis was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female AA and NHPI MA enrollees who were appropriately screened for osteoporosis was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentage of eligible female Black MA enrollees who were appropriately screened for osteoporosis was **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female Hispanic MA enrollees who were appropriately screened for osteoporosis was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female White MA enrollees who were appropriately screened for osteoporosis was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.

Osteoporosis Management in Women Who Had a Fracture

Percentage of female MA enrollees aged 67 to 85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture, by race and ethnicity, Reporting Year 2023



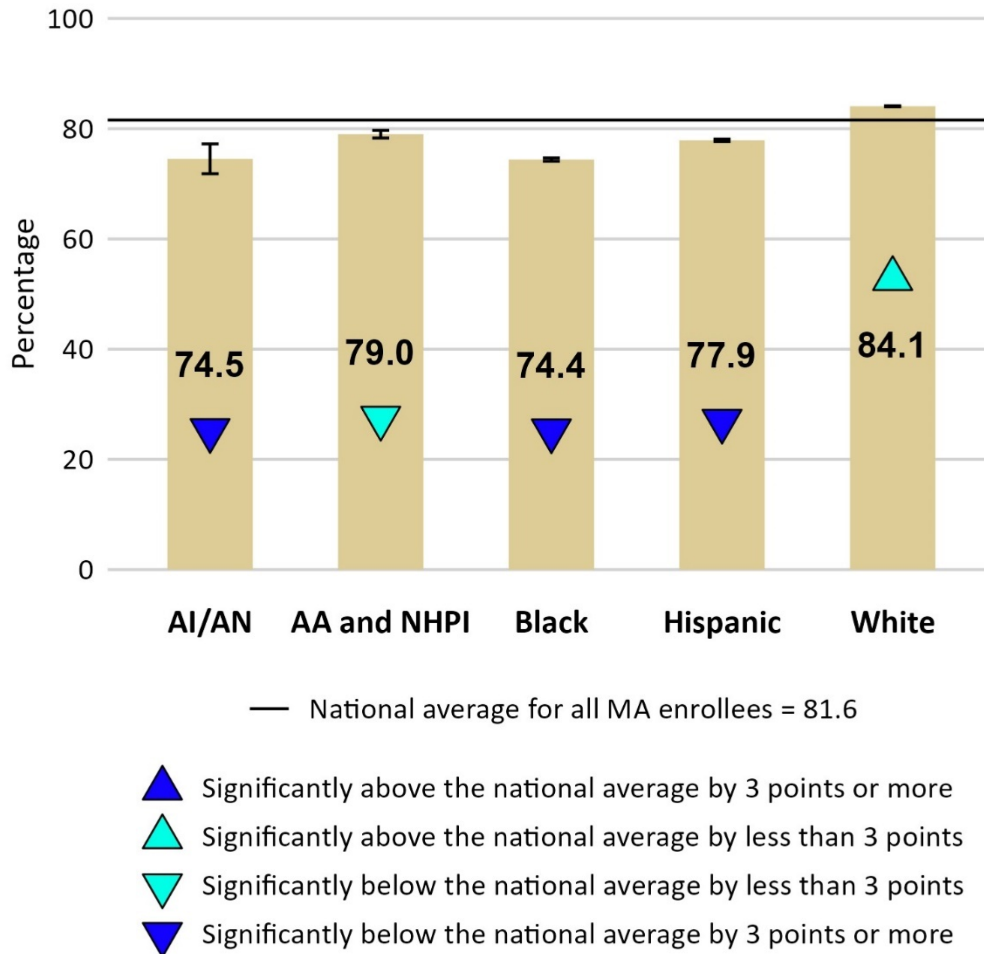
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentage of eligible female AA and NHPI MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female Black MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentage of eligible female Hispanic MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentage of eligible female White MA enrollees who had either a bone mineral density test or a prescription for a drug to treat osteoporosis was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by race and ethnicity, Reporting Year 2023



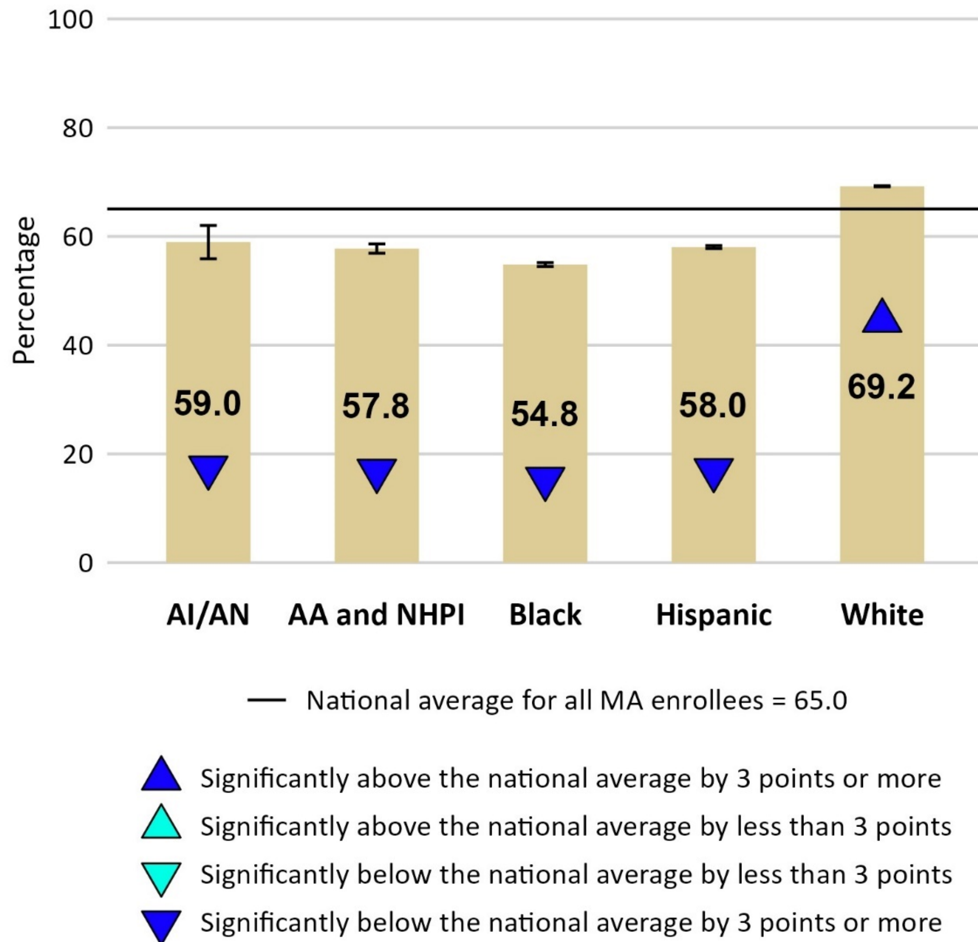
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of eligible AI/AN MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible AA and NHPI MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible Black MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 180 days, by race and ethnicity, Reporting Year 2023



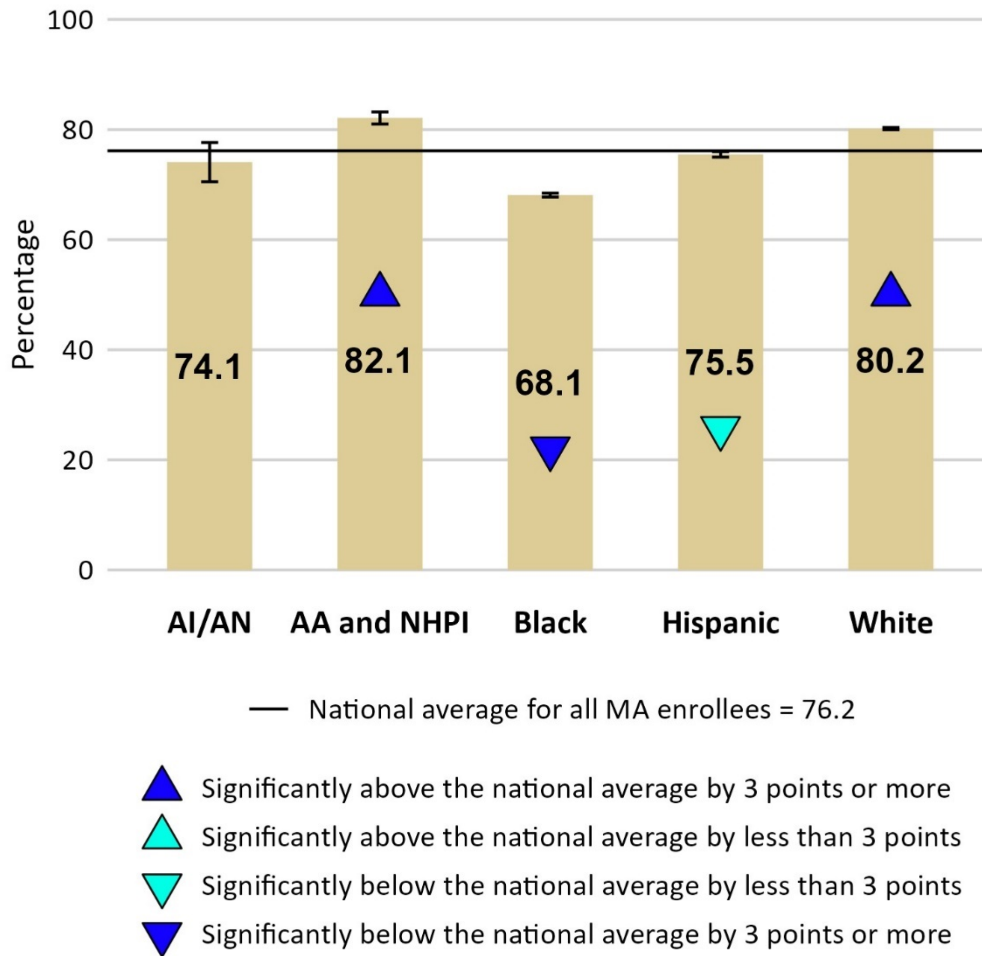
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of eligible AI/AN MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible AA and NHPI MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible Black MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of eligible White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all eligible MA enrollees by more than 3 percentage points.

Adherence to Antipsychotic Medications for People with Schizophrenia

Percentage of MA enrollees aged 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period, by race and ethnicity, Reporting Year 2023



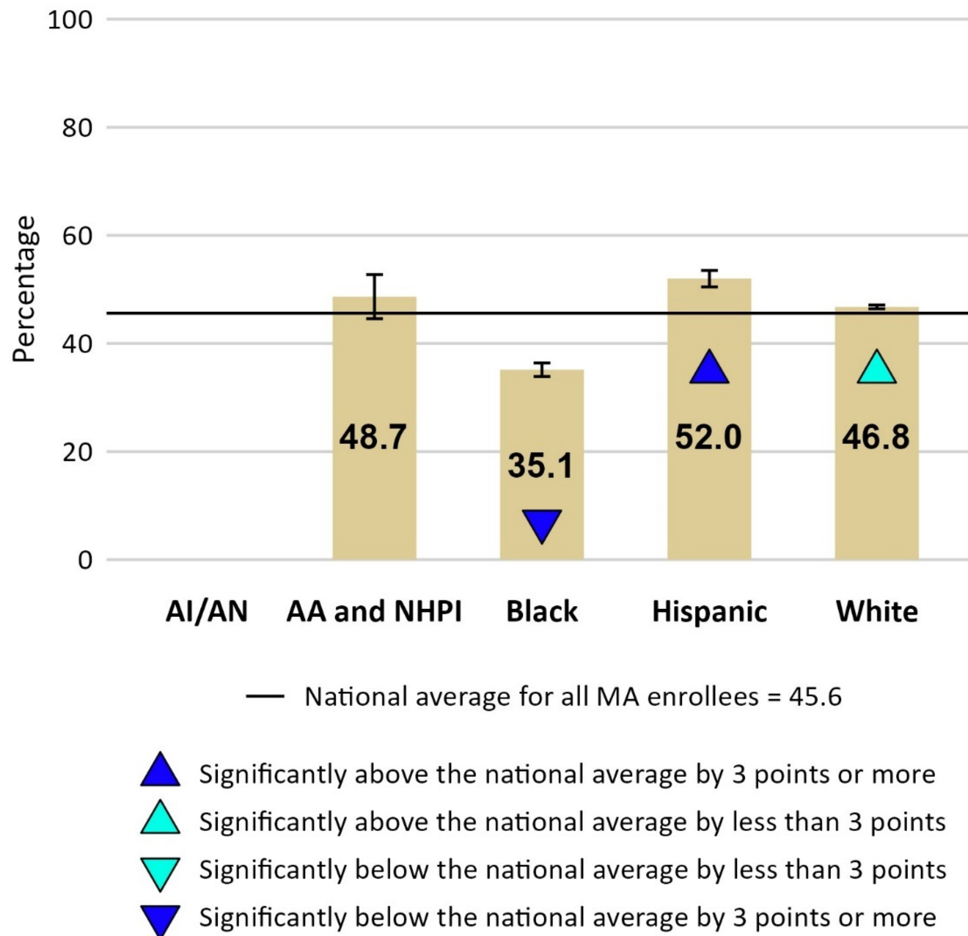
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **similar to** the national average for all MA enrollees with schizophrenia or schizoaffective disorder.
- The percentage of AA and NHPI MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **above** the national average for all MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points.
- The percentage of Black MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **below** the national average for all MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points.
- The percentage of Hispanic MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **below** the national average for all MA enrollees with schizophrenia or schizoaffective disorder by less than 3 percentage points.
- The percentage of White MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **above** the national average for all MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points.

Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 45.6

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

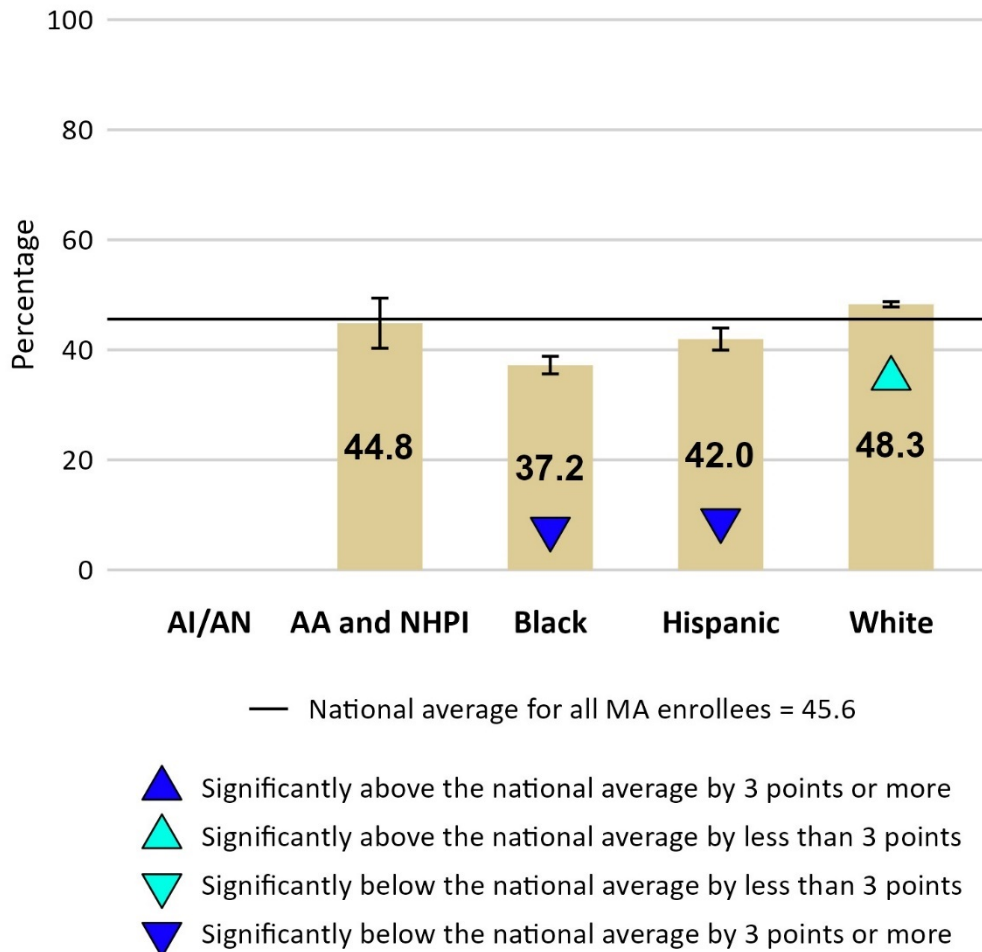
[†] Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult AA and NHPI MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult Black MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult White MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older[†] who had an ED visit for selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of the ED visit, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

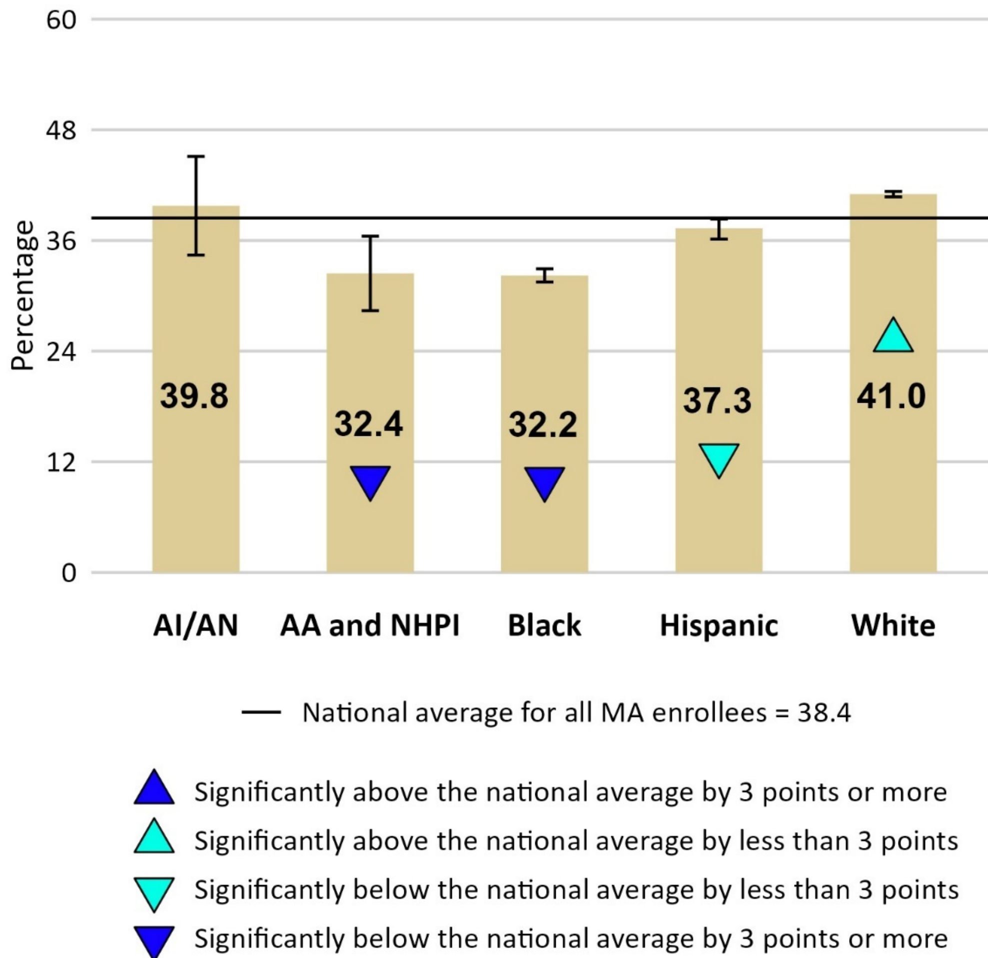
[†] Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult AA and NHPI MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult Black MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult White MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)

Percentage of MA enrollees aged 18 years and older[†] who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

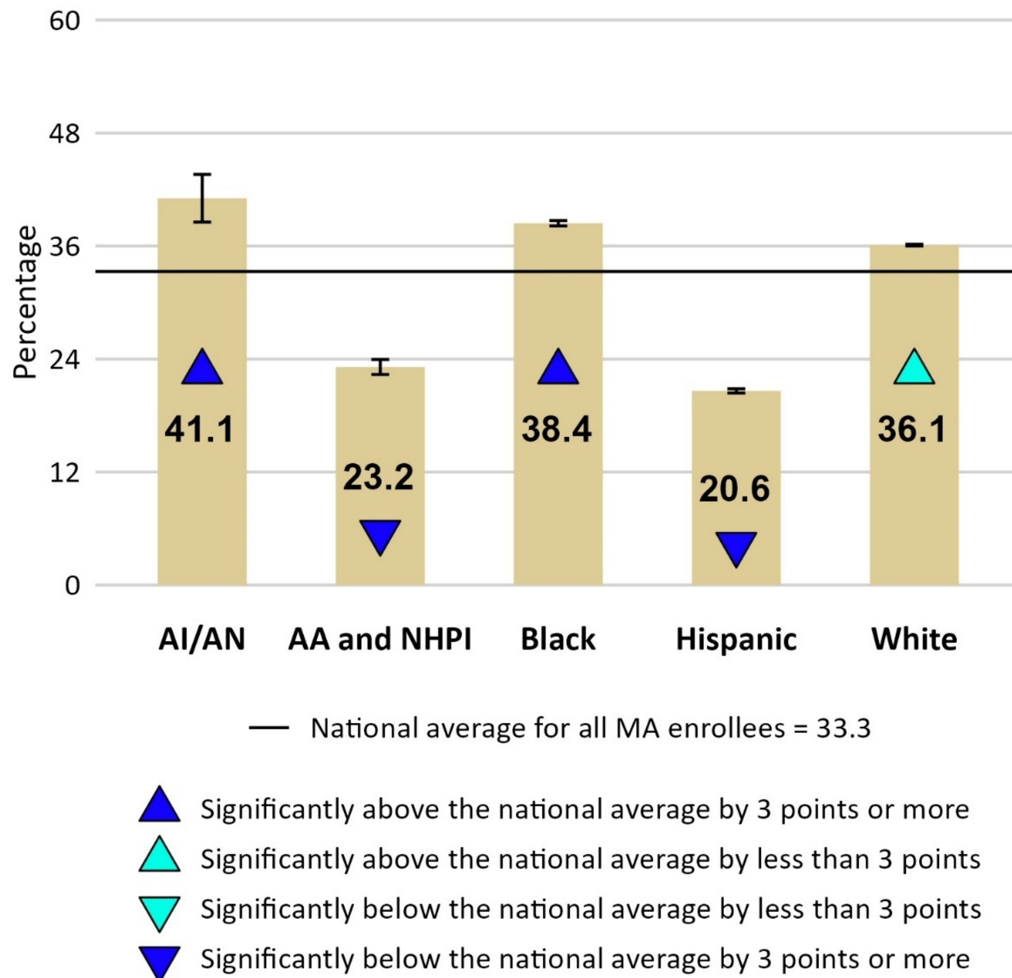
[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Disparities

- The percentage of AI/AN MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **similar to** the national average for all eligible MA enrollees.
- The percentage of AA and NHPI MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of Black MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of White MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Initiation of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older† with a new episode of AOD dependence who initiated‡ treatment within 14 days of the diagnosis, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

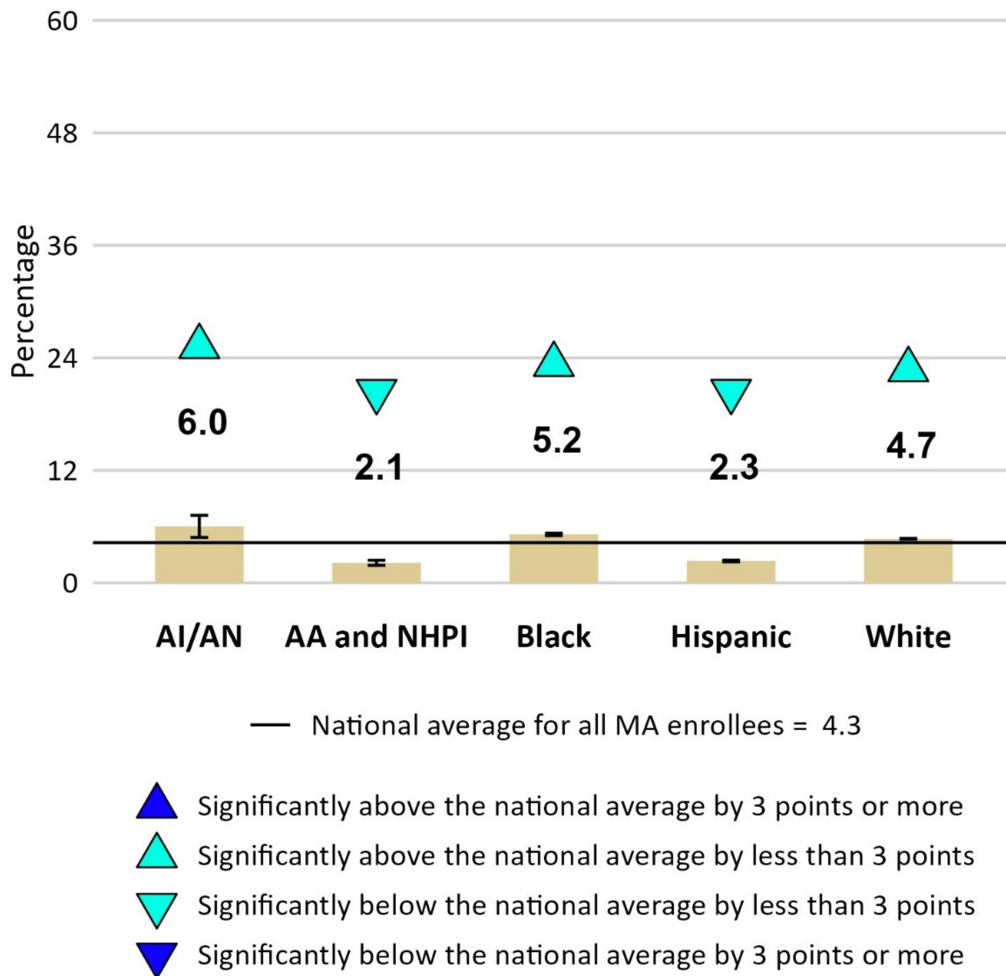
‡ Initiation might occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Disparities

- The percentage of AI/AN MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of AA and NHPI MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of Black MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of Hispanic MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible MA enrollees by more than 3 percentage points.
- The percentage of White MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Engagement of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

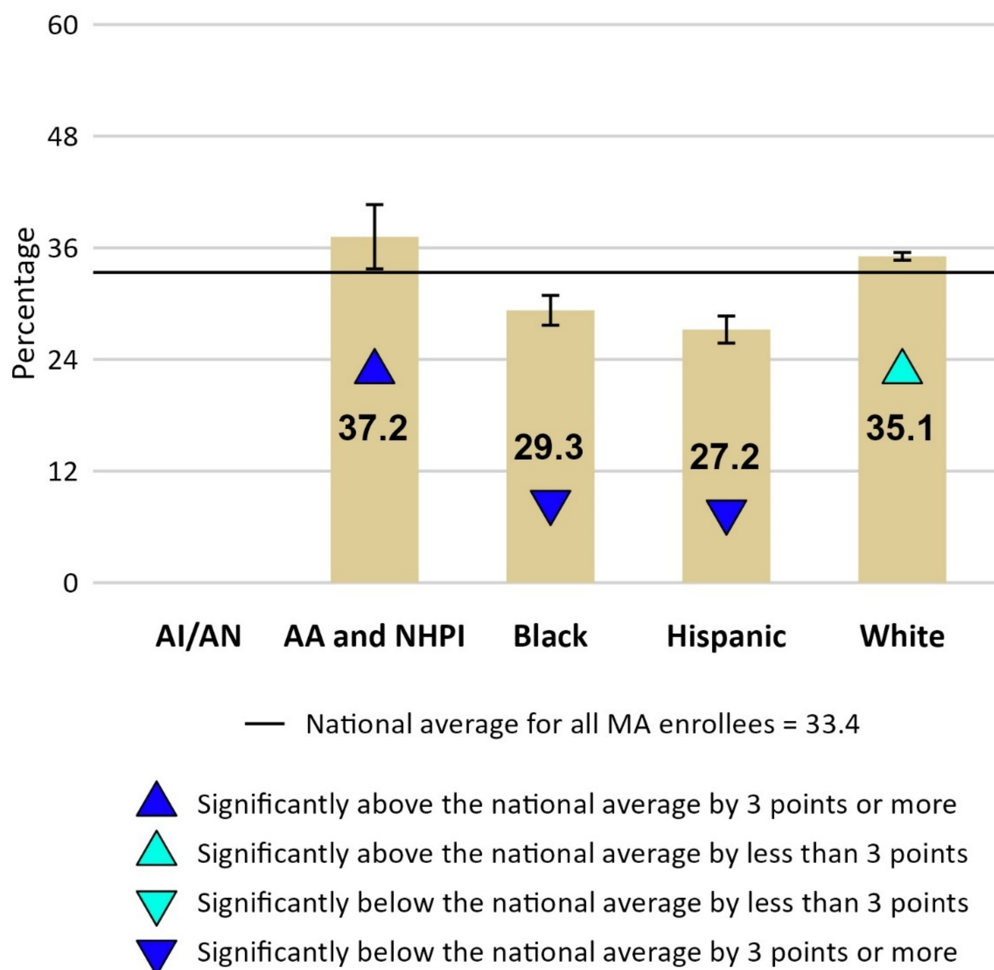
[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Disparities

- The percentage of AI/AN MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of AA and NHPI MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of Black MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of Hispanic MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of White MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

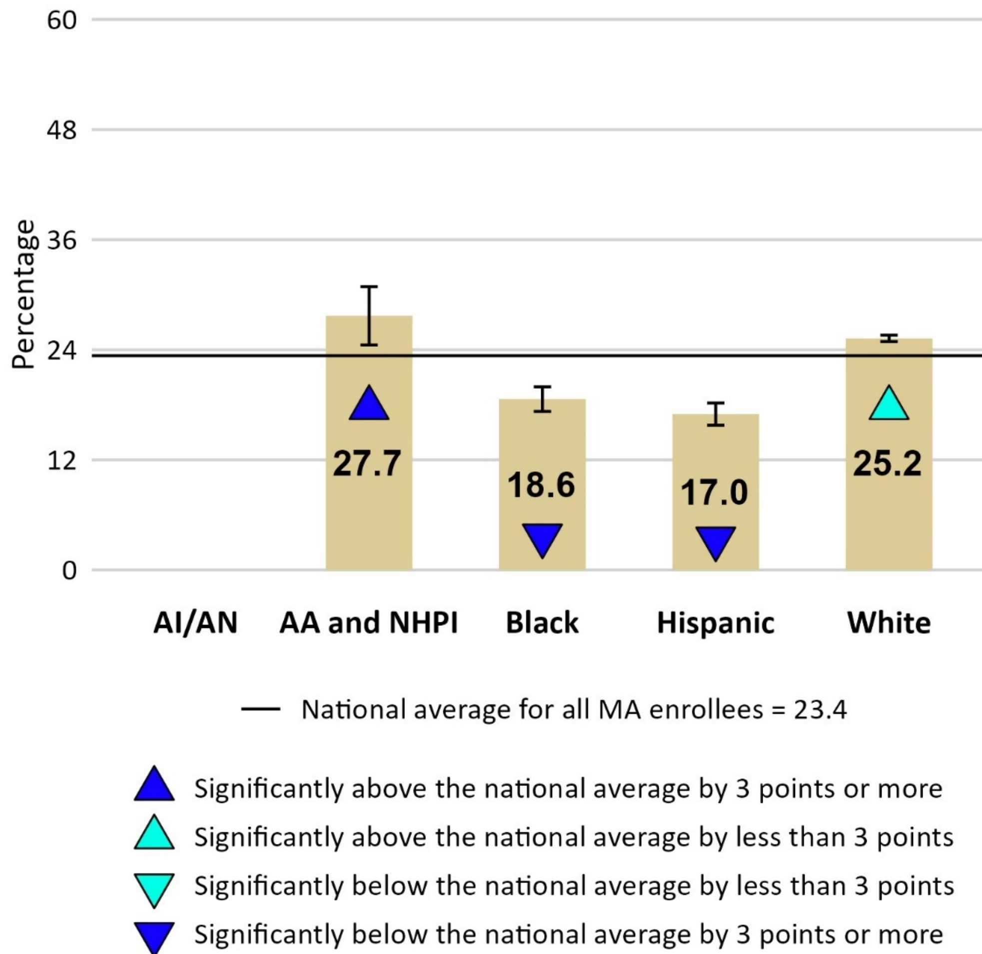
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult AA and NHPI MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Black MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult White MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

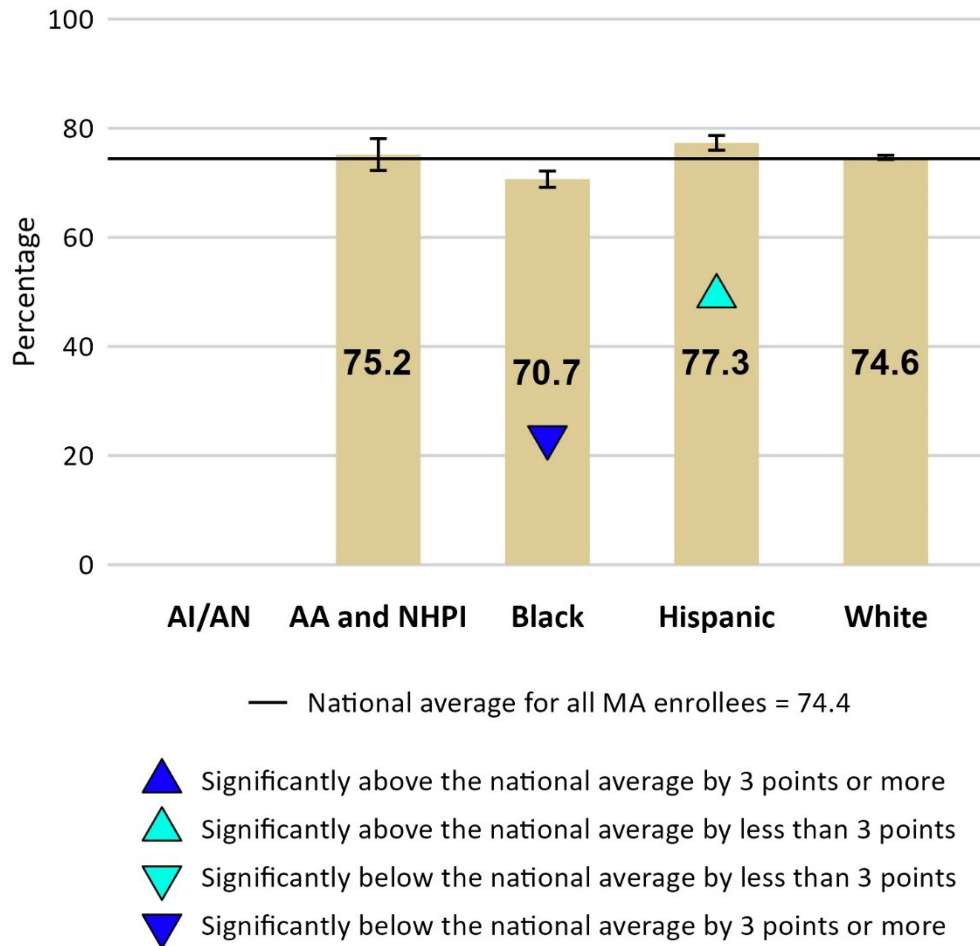
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult AA and NHPI MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Black MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult White MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

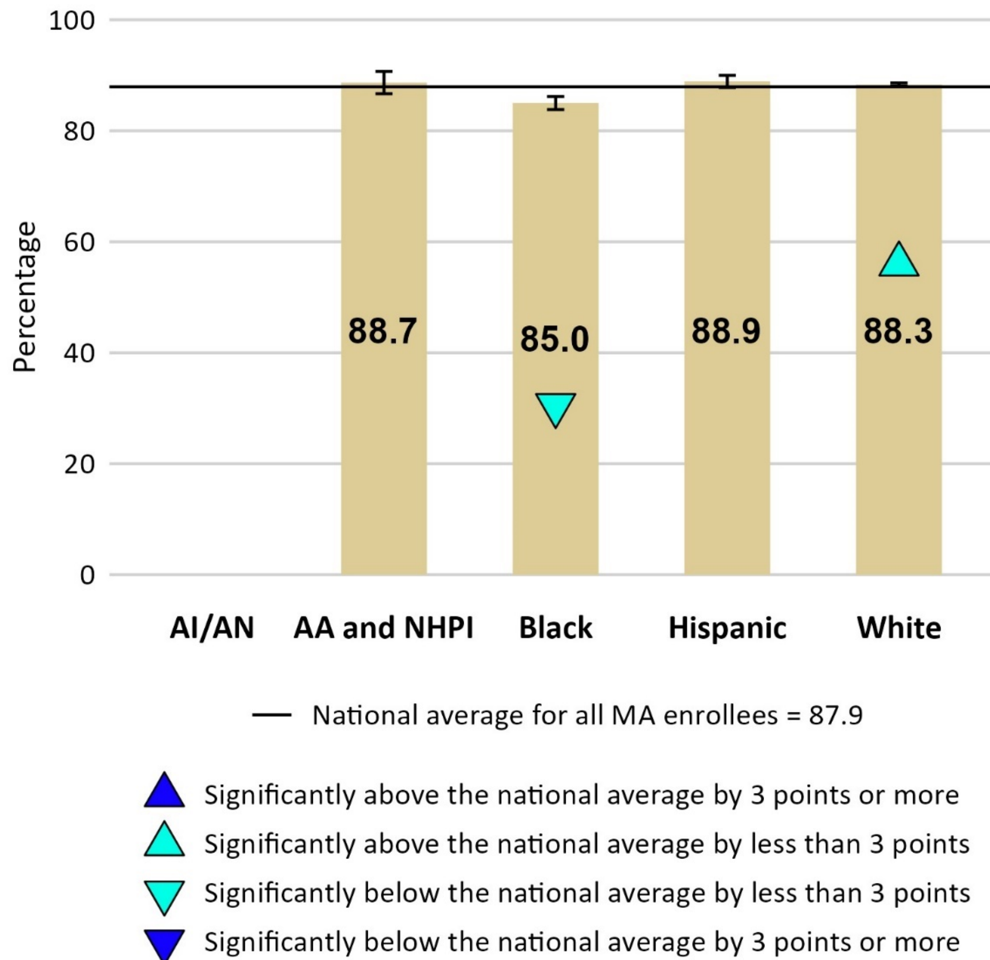
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult AA and NHPI MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult Black MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult White MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth services) was provided within 30 days of discharge, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report.

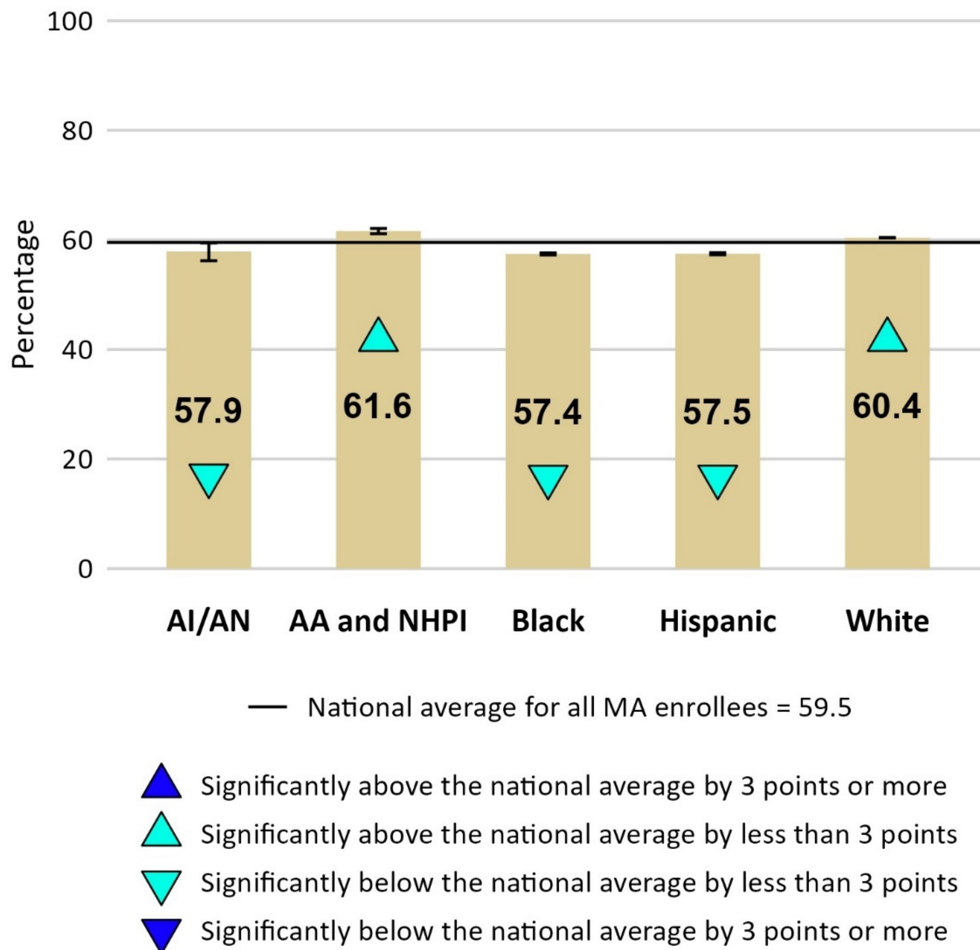
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult AA and NHPI MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult Black MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult White MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Percentage of MA enrollees aged 65 years and older[†] with multiple high-risk chronic conditions[‡] who received follow-up care within seven days of an ED visit, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

[‡] Conditions include COPD and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, AMI, atrial fibrillation, and stroke and transient ischemic attack.

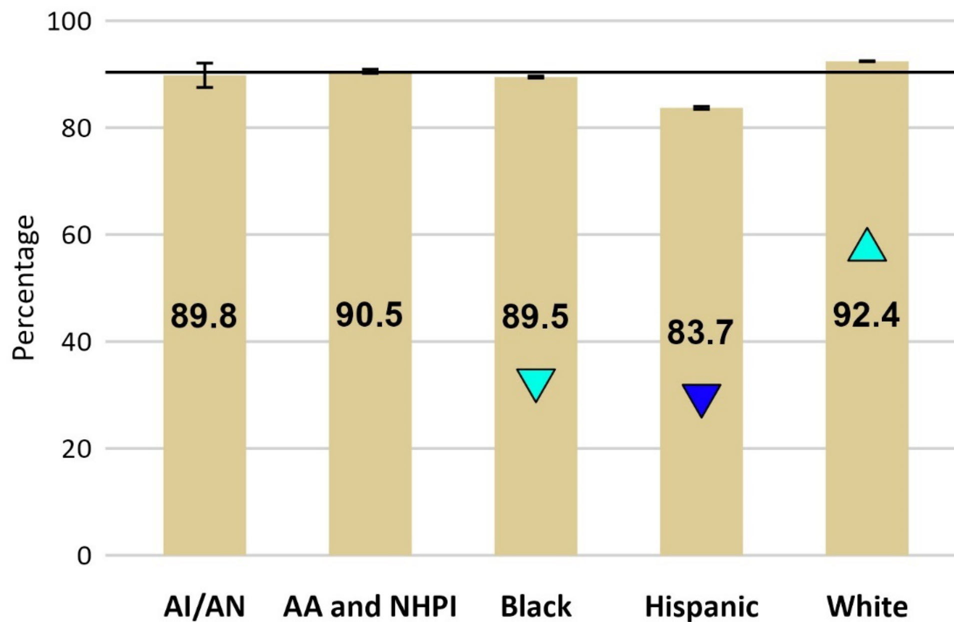
Disparities

- The percentage of older adult AI/AN MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult AA and NHPI MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult Black MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult White MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Clinical Care: Overuse and Appropriate Use of Medication

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,[†] by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 90.4

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

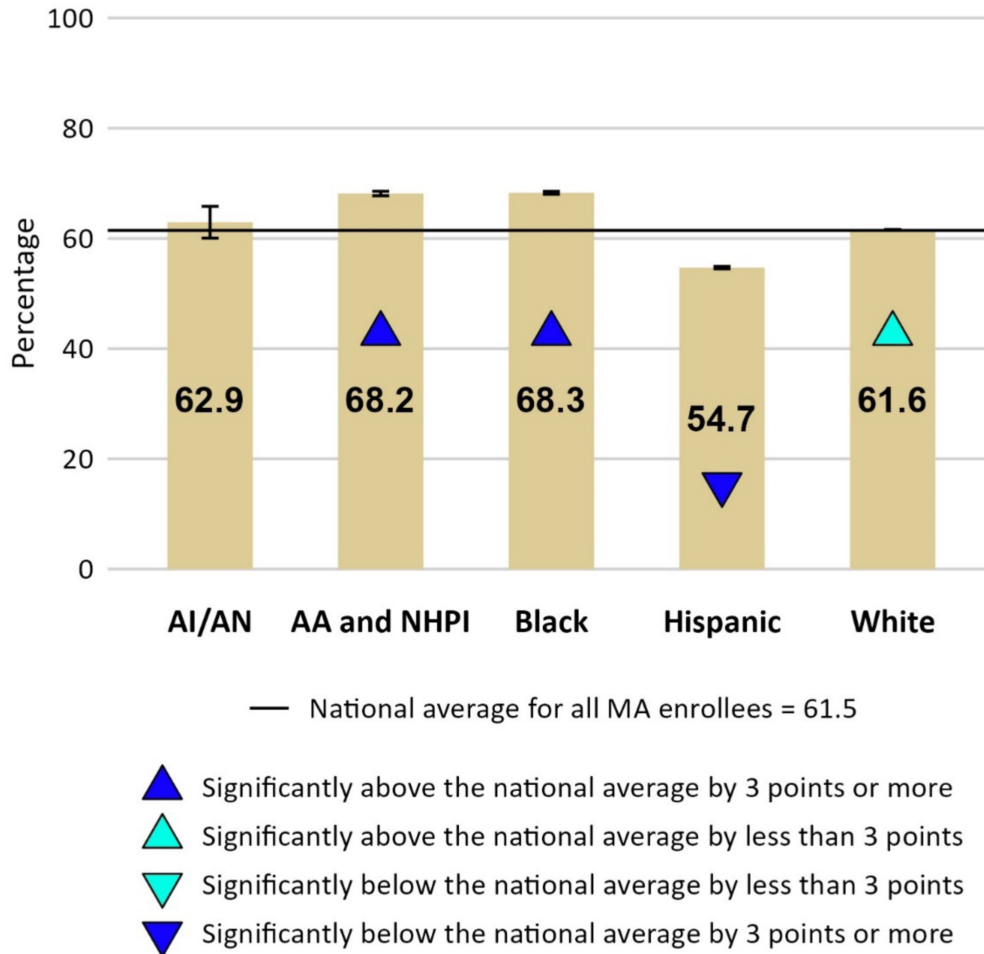
[†] This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) or nonaspirin NSAIDs.

Disparities

- The percentage of older adult AI/AN MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult AA and NHPI MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult Black MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult White MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,[†] by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 61.5

- ▲ Significantly above the national average by 3 points or more
- △ Significantly above the national average by less than 3 points
- ▽ Significantly below the national average by less than 3 points
- ▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

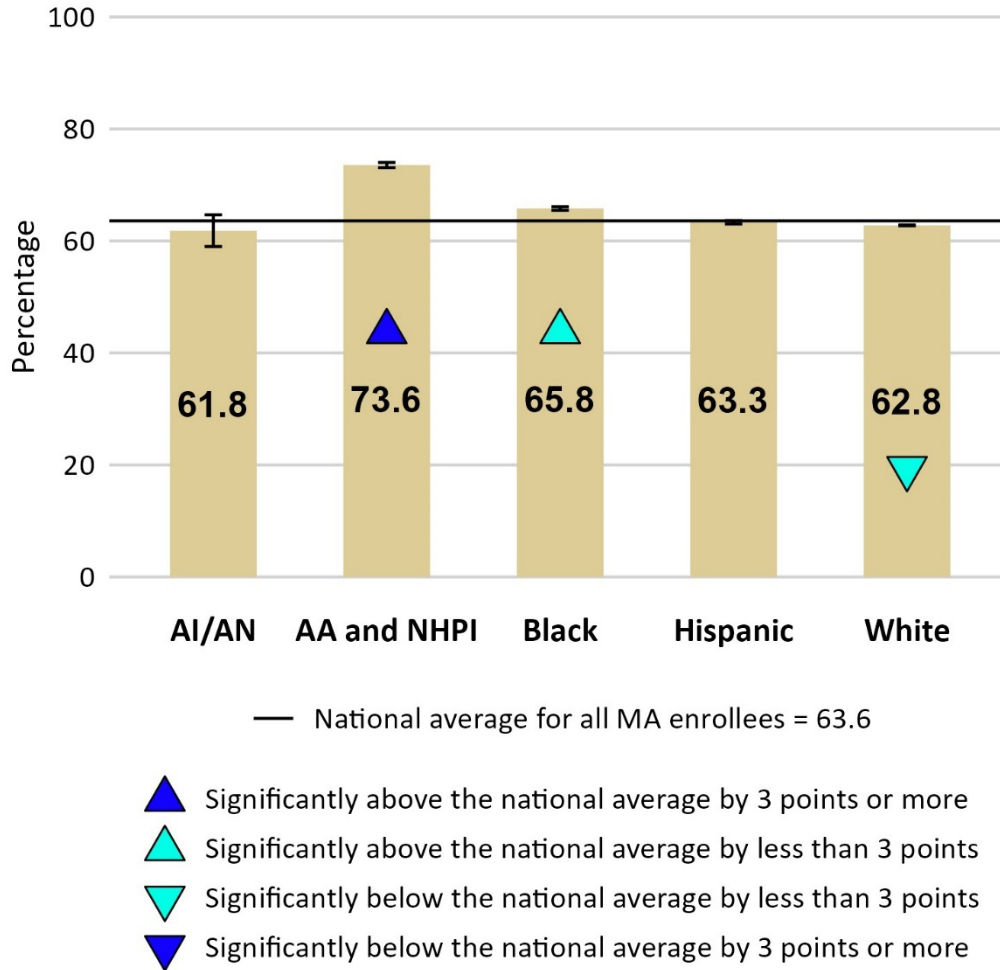
[†] This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Disparities

- The percentage of older adult AI/AN MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult AA and NHPI MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Black MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult White MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

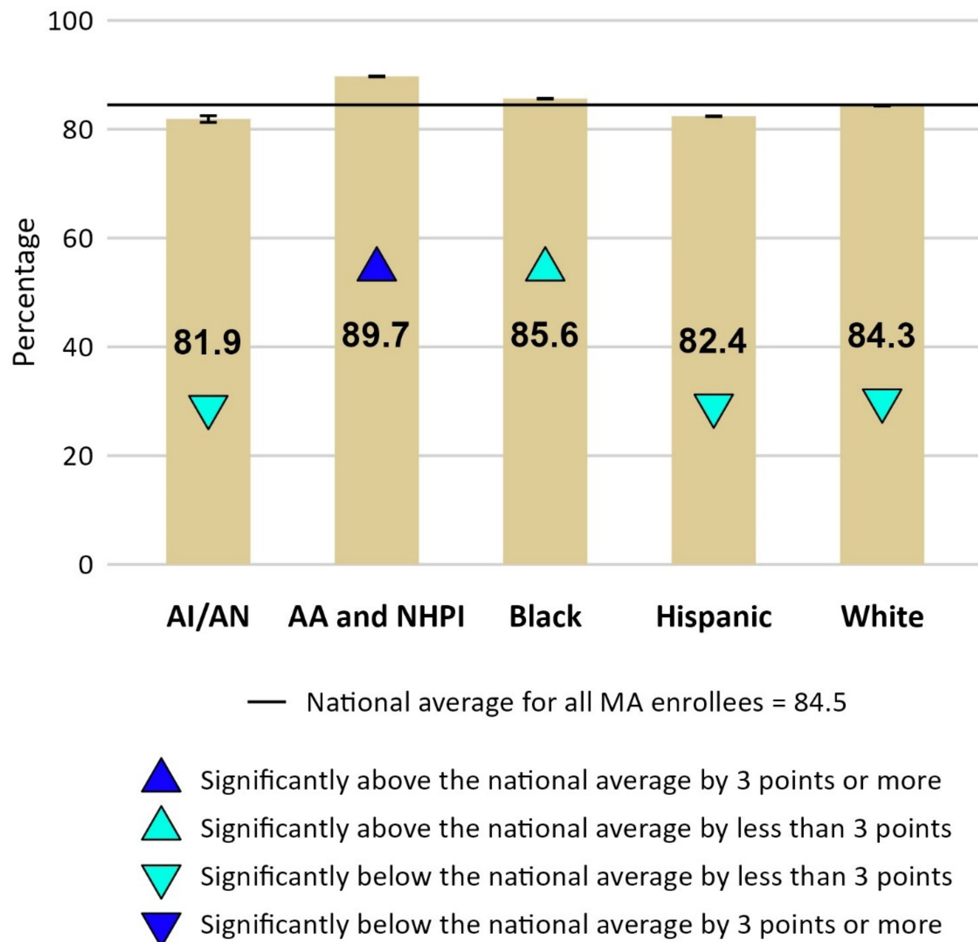
† This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake inhibitors, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Disparities

- The percentage of older adult AI/AN MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult AA and NHPI MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Black MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult White MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Avoiding Use of High-Risk Medications in Older Adults

Percentage of MA enrollees aged 65 years and older who were not prescribed two or more high-risk medications from the same drug class in the past year, by race and ethnicity, Reporting Year 2023



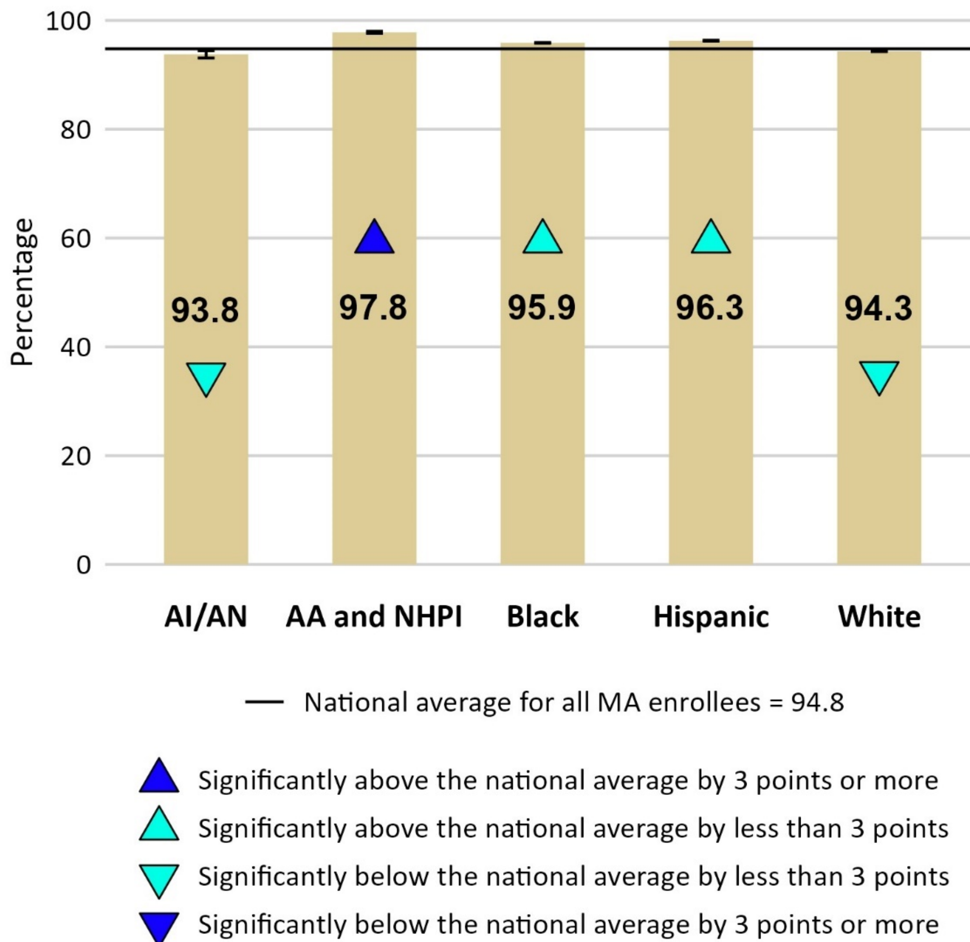
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of older adult AI/AN MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult AA and NHPI MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.
- The percentage of older adult Black MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult Hispanic MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult White MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage† for more than 14 days in the past year, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

† Average morphine equivalent dose ≥ 90 mg.

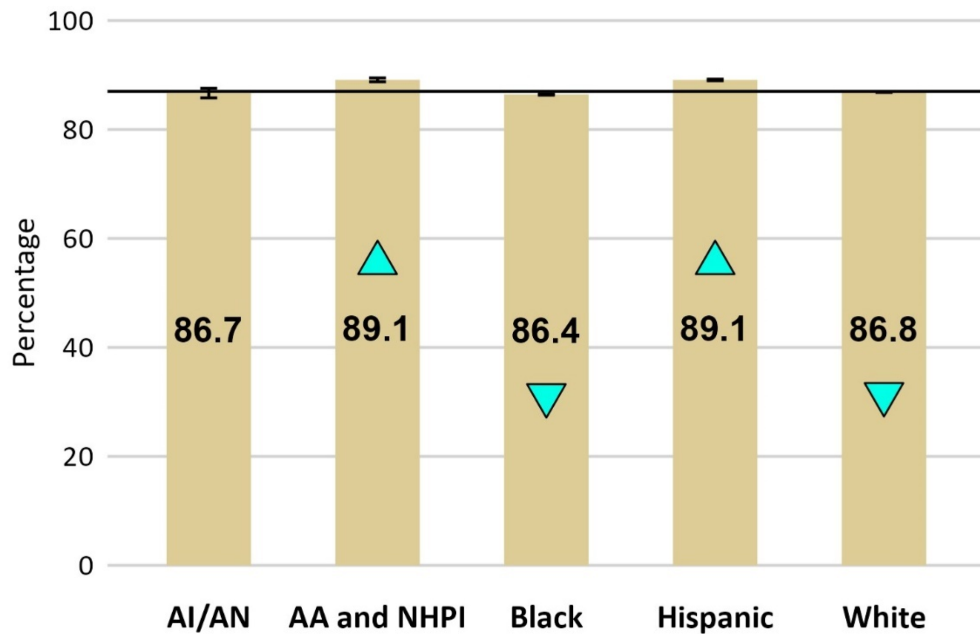
Disparities

- The percentage of AI/AN MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of AA and NHPI MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all MA enrollees by more than 3 percentage points.[†]
- The percentage of Black MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Hispanic MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of White MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.

[†] Prior to rounding.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 87.0

- Significantly above the national average by 3 points or more
- Significantly above the national average by less than 3 points
- Significantly below the national average by less than 3 points
- Significantly below the national average by 3 points or more

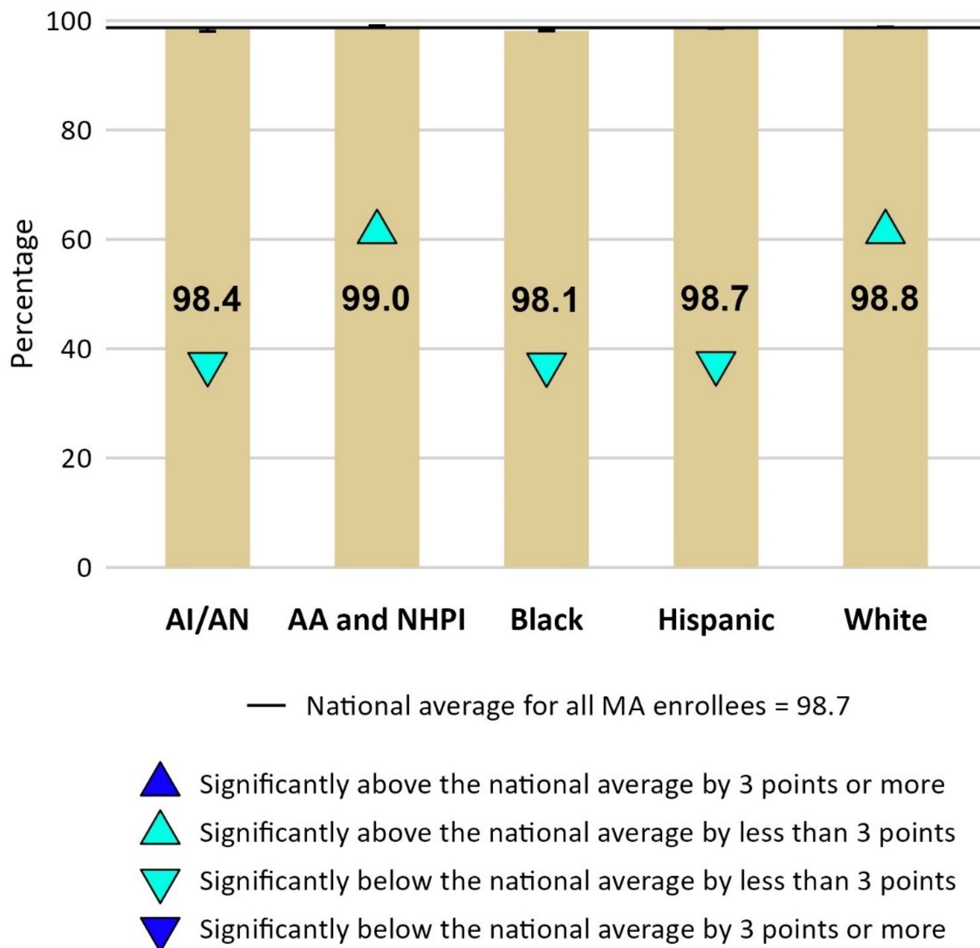
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of AI/AN MA enrollees for whom use of opioids from multiple prescribers was avoided was **similar to** the national average for all MA enrollees.
- The percentage of AA and NHPI MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Black MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Hispanic MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of White MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by race and ethnicity, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

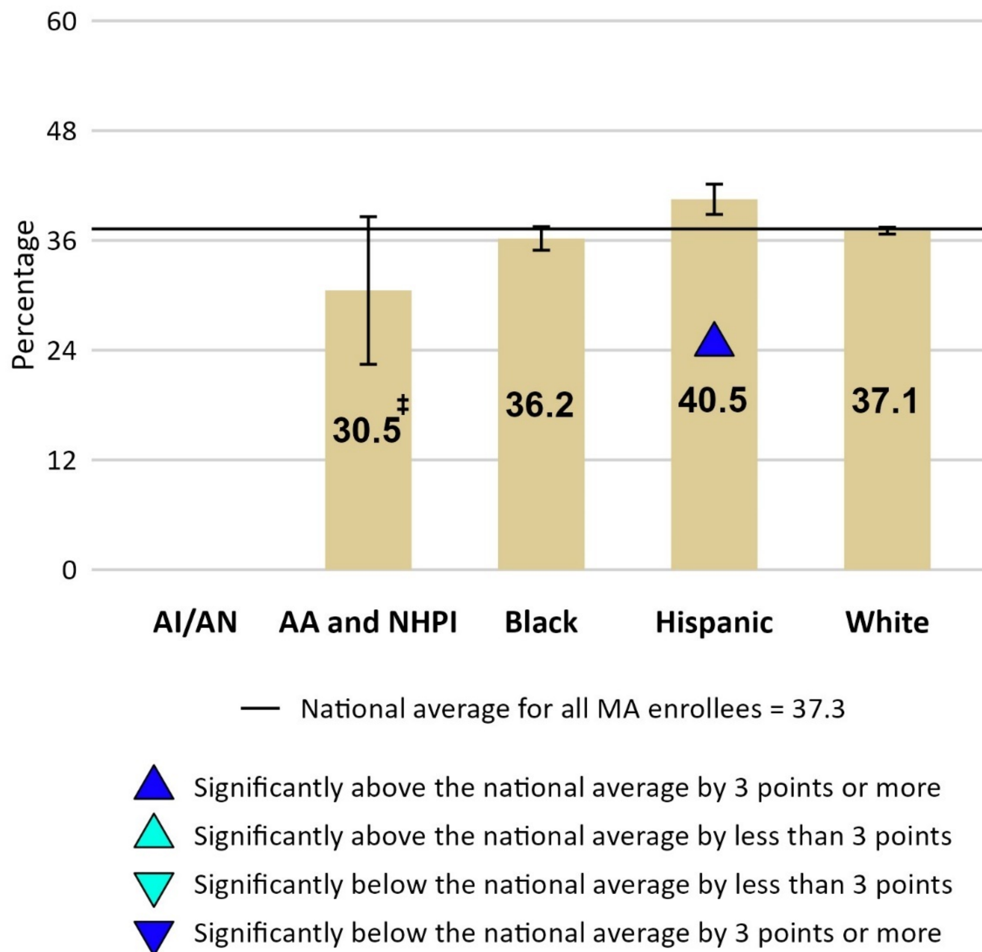
Disparities

- The percentage of AI/AN MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of AA and NHPI MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Black MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Hispanic MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average[†] for all MA enrollees by less than 3 percentage points.
- The percentage of White MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.

[†] Prior to rounding

Pharmacotherapy for Opioid Use Disorder

Percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees aged 18 years and older[†] that continued for at least 180 days, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 37.3

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for AI/AN MA enrollees is not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, all group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

‡ This score is based on fewer than 400 completed measures, and thus its accuracy might be low.

[†] Although the lower-bound age cutoff for this HEDIS measure is 16 years old, the data used in this report are limited to adults.

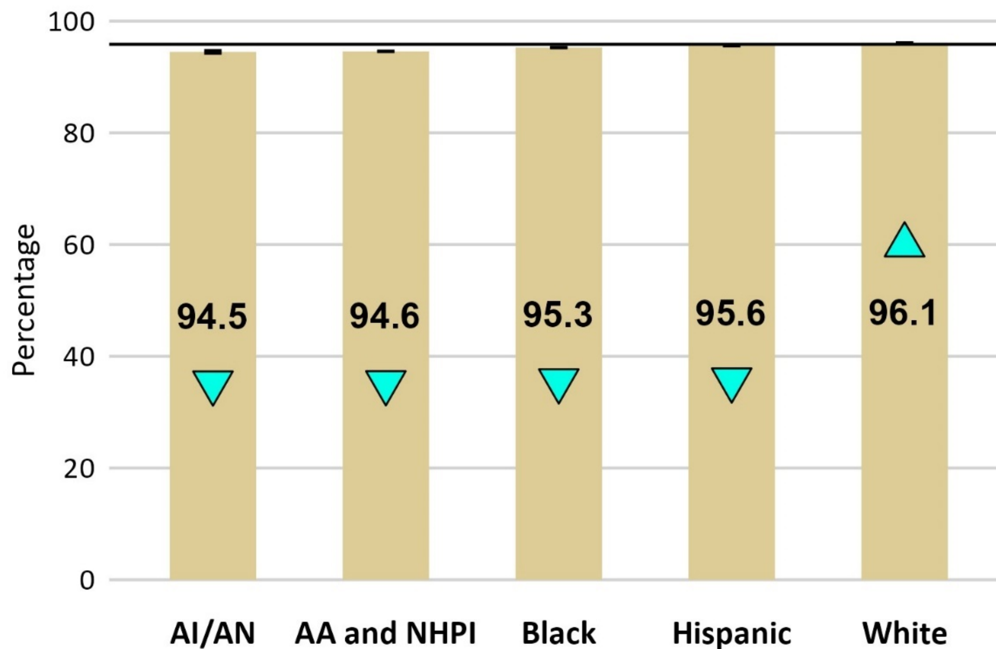
Disparities

- The percentage of opioid use disorder pharmacotherapy treatment events among AA and NHPI MA enrollees that continued for at least 180 days was **similar to** the national average for all MA enrollees.
- The percentage of opioid use disorder pharmacotherapy treatment events among Black MA enrollees that continued for at least 180 days was **similar to** the national average for all MA enrollees.
- The percentage of opioid use disorder pharmacotherapy treatment events among Hispanic MA enrollees that continued for at least 180 days was **above** the national average for all MA enrollees by more than 3 percentage points.
- The percentage of opioid use disorder pharmacotherapy treatment events among White MA enrollees that continued for at least 180 days was **similar to** the national average for all MA enrollees.

Clinical Care: Access to and Availability of Care

Adult Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 20 years and older who had an ambulatory or preventive care visit in the past year, by race and ethnicity, Reporting Year 2023



— National average for all MA enrollees = 95.9

- Significantly above the national average by 3 points or more
- Significantly above the national average by less than 3 points
- Significantly below the national average by less than 3 points
- Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

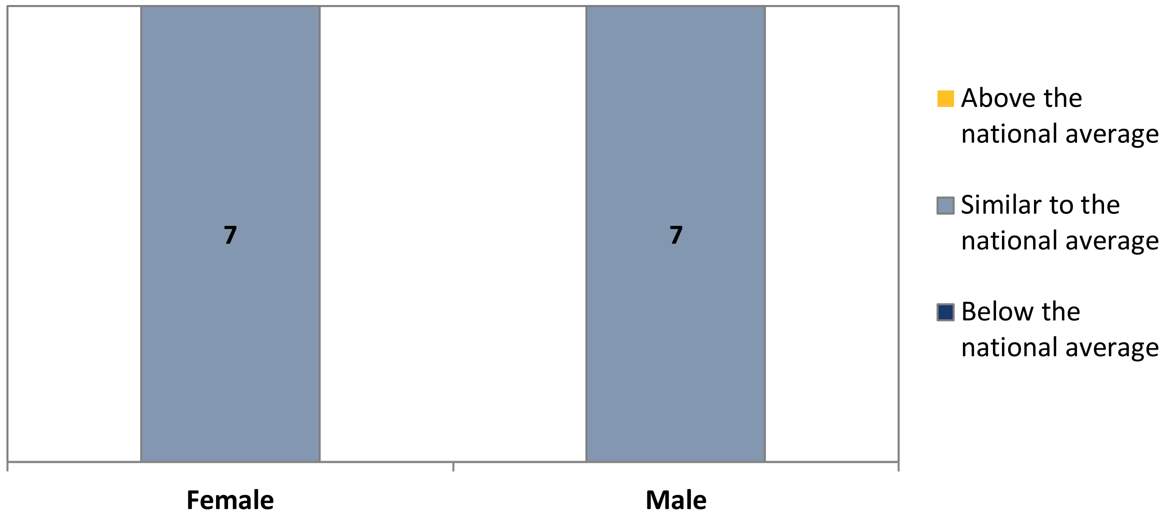
Disparities

- The percentage of AI/AN MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of AA and NHPI MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Black MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of Hispanic MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of White MA enrollees who had an ambulatory or preventive care visit in the past year was **above** the national average for all MA enrollees by less than 3 percentage points.

Appendix B: Disparities in Health Care in Medicare Advantage by Sex

Disparities in Care by Sex: All Patient Experience Measures

Number of patient experience measures (out of 7) for which female and male MA enrollees had results that were above, similar to, or below the national average in 2023



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.

Each group is compared with the national average for all MA enrollees.

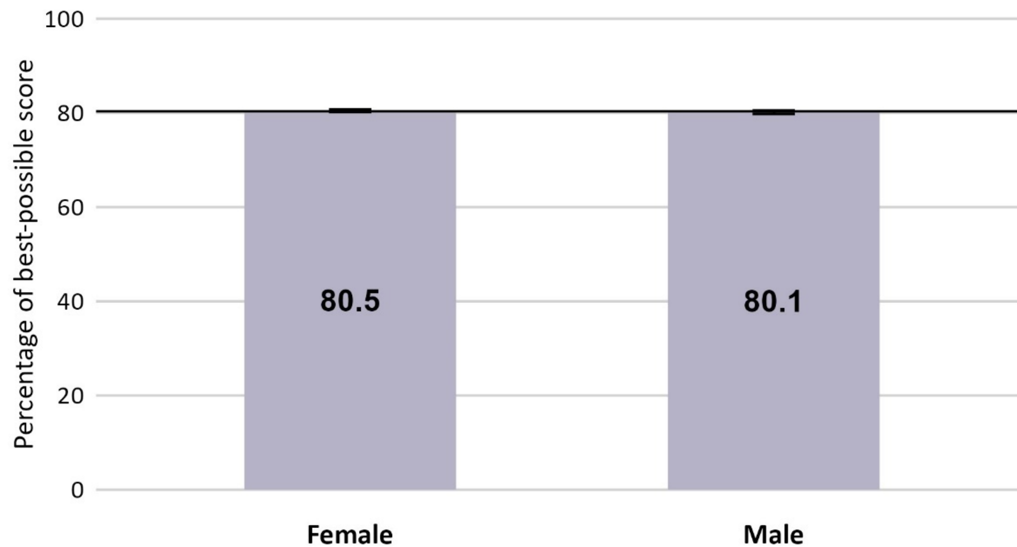
- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points† on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group received care that was below the national average. The difference is statistically significant and equal to or larger than 3 points† on a 0–100 scale.

† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for enrollees to get needed care,[†] by sex, 2023



— National average for all MA enrollees = 80.3

Significantly above the national average by 3 points or more
Significantly above the national average by less than 3 points
Significantly below the national average by less than 3 points
Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.

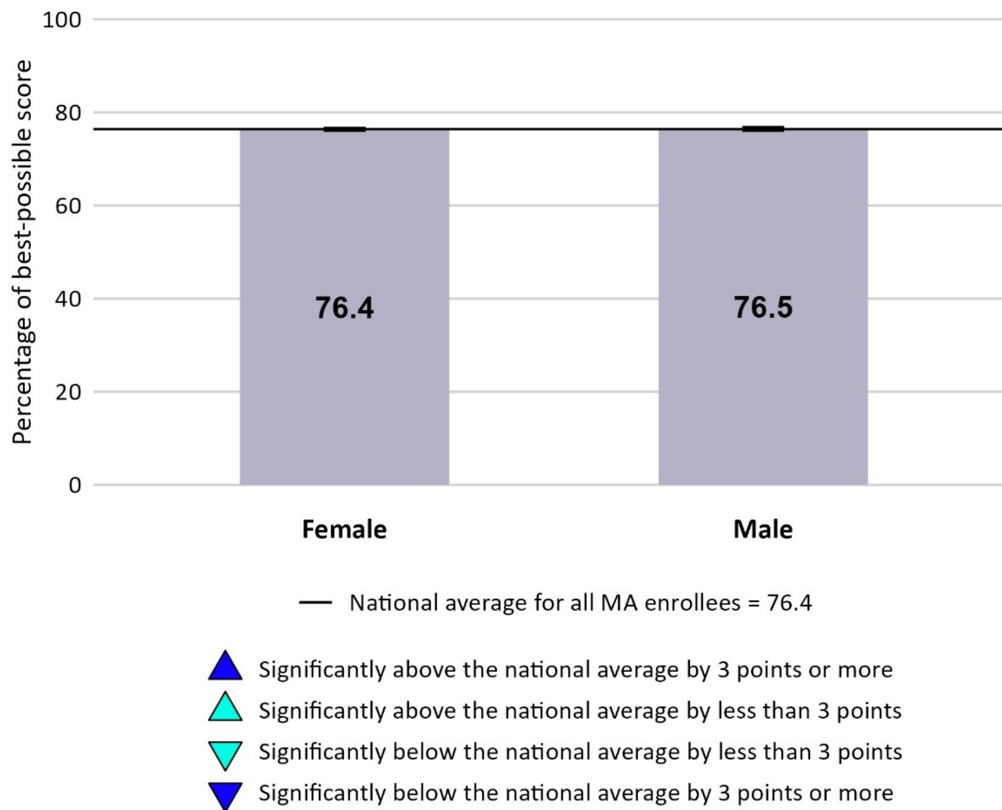
Disparities

- Female MA enrollees reported experiences getting needed care that were **similar to** the national average for all MA enrollees.
- Male MA enrollees reported experiences getting needed care that were **similar to** the national average for all MA enrollees.

[†] This includes how often in the last six months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly enrollees get appointments and care,† by sex, 2023



— National average for all MA enrollees = 76.4

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.

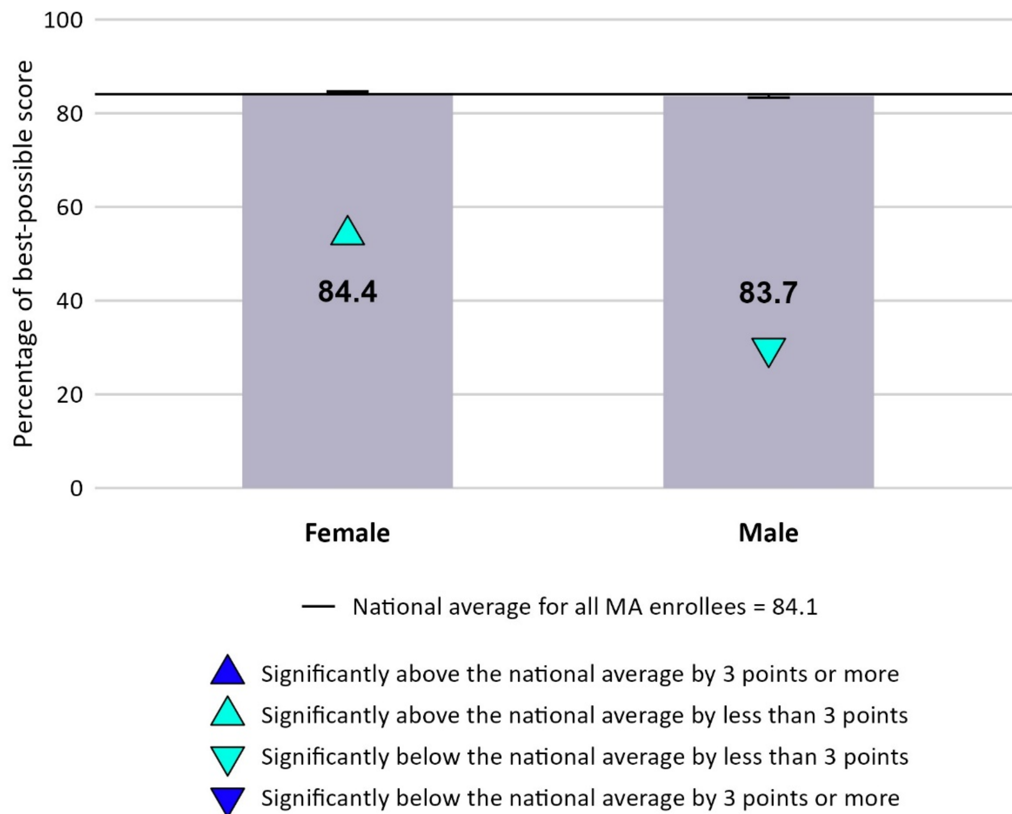
Disparities

- Female MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees.
- Male MA enrollees reported experiences with getting appointments and care quickly that were **similar to** the national average for all MA enrollees.

† This includes how often in the last six months patients got care that was needed right away, as well as how easy it was to get appointments for checkups and routine care.

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.

Disparities

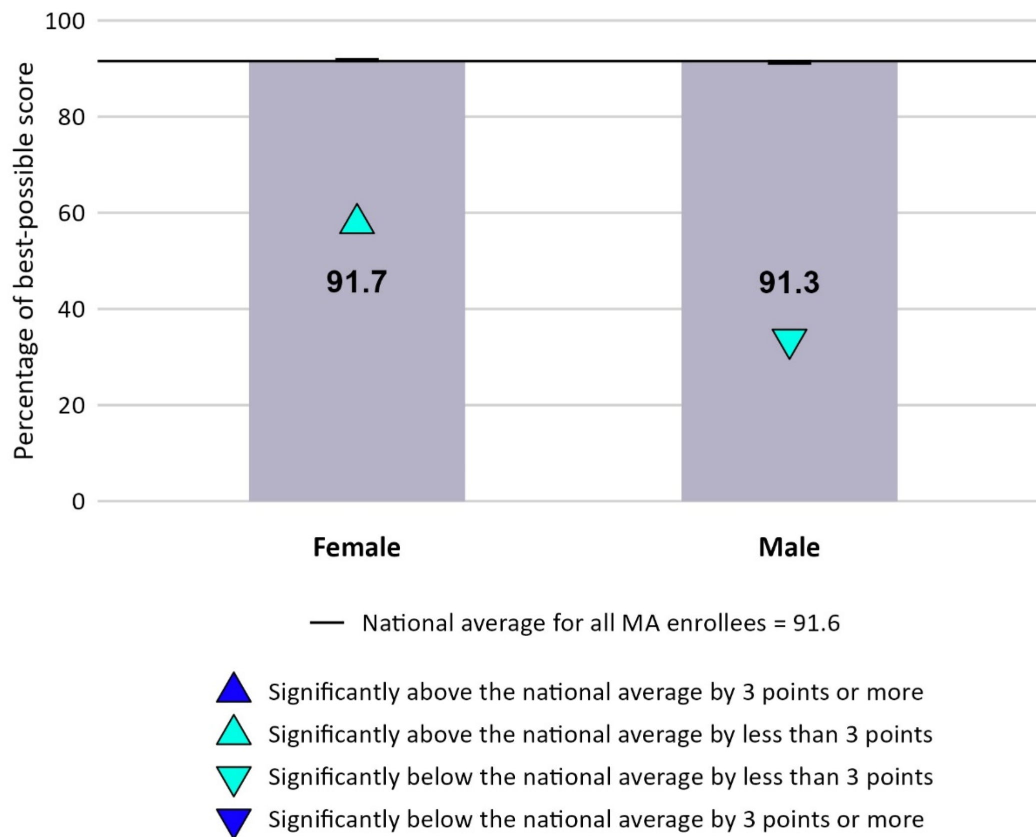
- Female MA enrollees reported experiences with customer service that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.‡
- Male MA enrollees reported experiences with customer service that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

† This includes how often in the last six months health plan customer service staff provided the information or the help that plan members needed, how often plan members were treated with courtesy and respect, and how often forms from the health plan were easy to fill out.

‡ Unlike on p. 126, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.

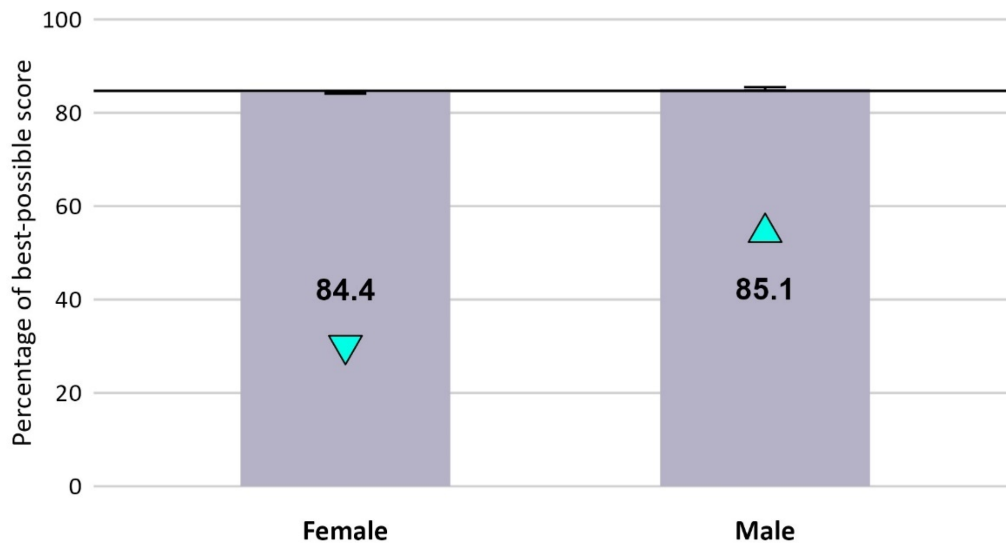
Disparities

- Female enrollees reported experiences with doctor communication that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Male MA enrollees reported experiences with doctor communication that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

[†] This includes how often in the last six months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent enough time with patients.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well enrollees' care was coordinated,† by sex, 2023



— National average for all MA enrollees = 84.7

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.

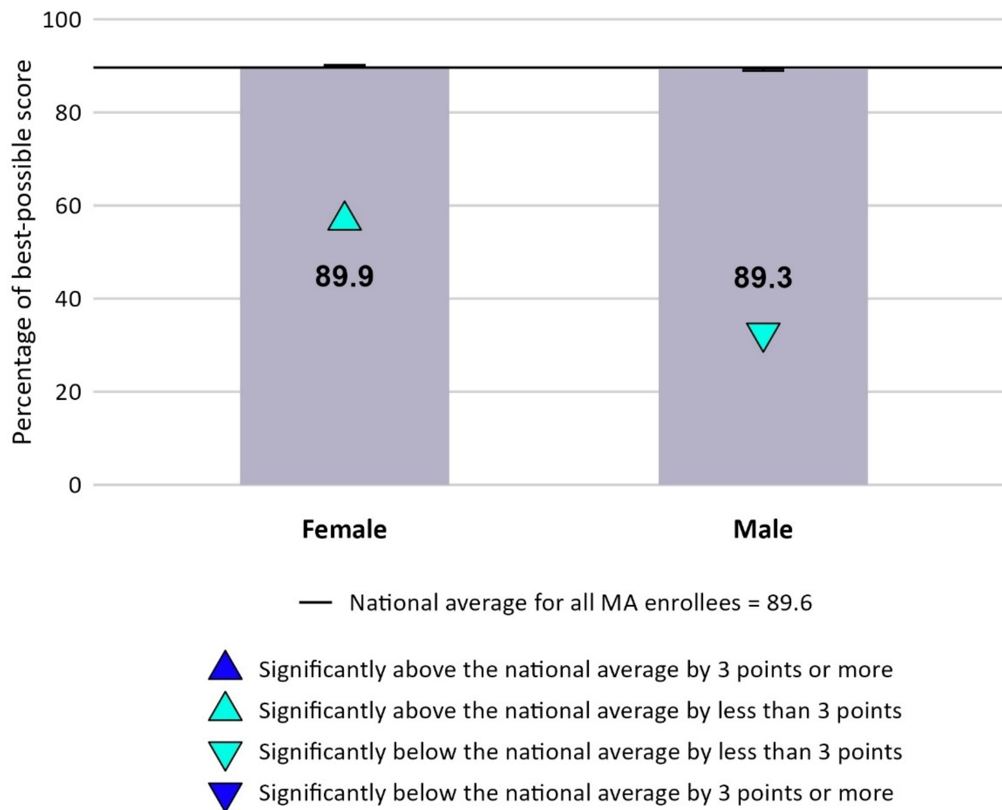
Disparities

- Female MA enrollees reported experiences with care coordination that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Male MA enrollees reported experiences with care coordination that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

† This includes how often in the last six months doctors had medical records and other information about patients' care at patients' scheduled appointments and how quickly patients received their test results.

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for enrollees to get the prescription drugs they need using their plan,† by sex, 2023



— National average for all MA enrollees = 89.6

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.

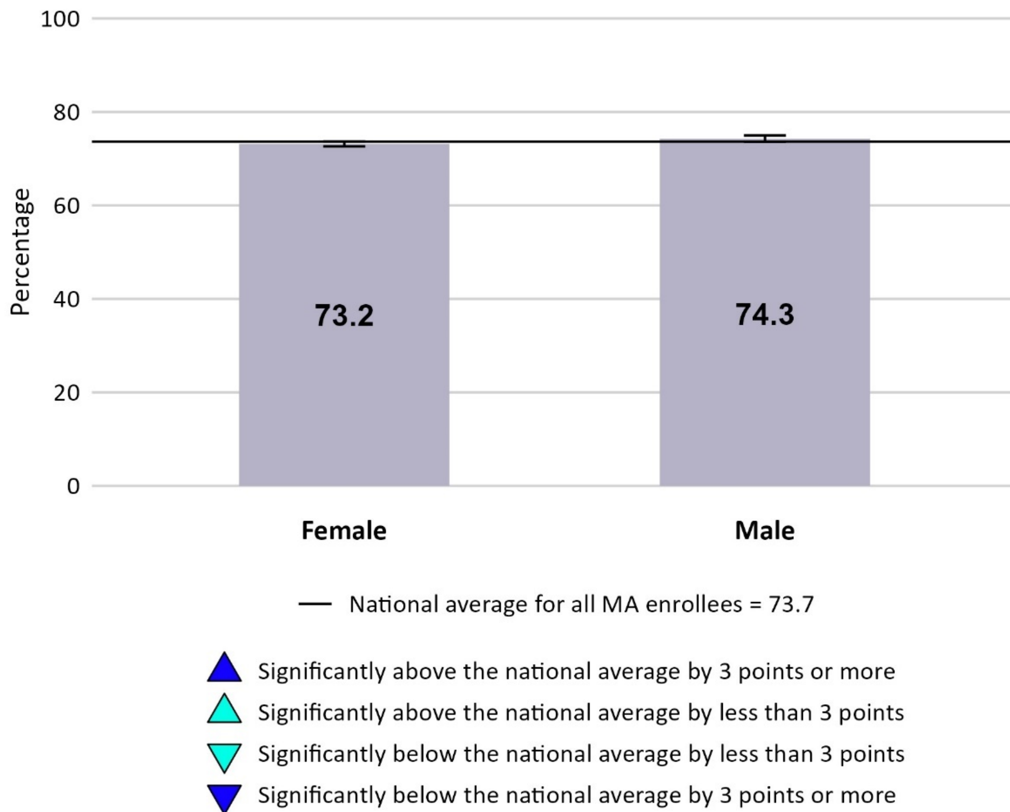
Disparities

- Female MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average for all MA enrollees by less than 3 points on a 0–100 scale.
- Male MA enrollees reported experiences with getting needed prescription drugs that were **below** the national average for all MA enrollees by less than 3 points on a 0–100 scale.

† This includes how often in the last six months it was easy to use the plan to get prescribed medications and how easy it was to fill prescriptions at a pharmacy or by mail.

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by sex, 2023



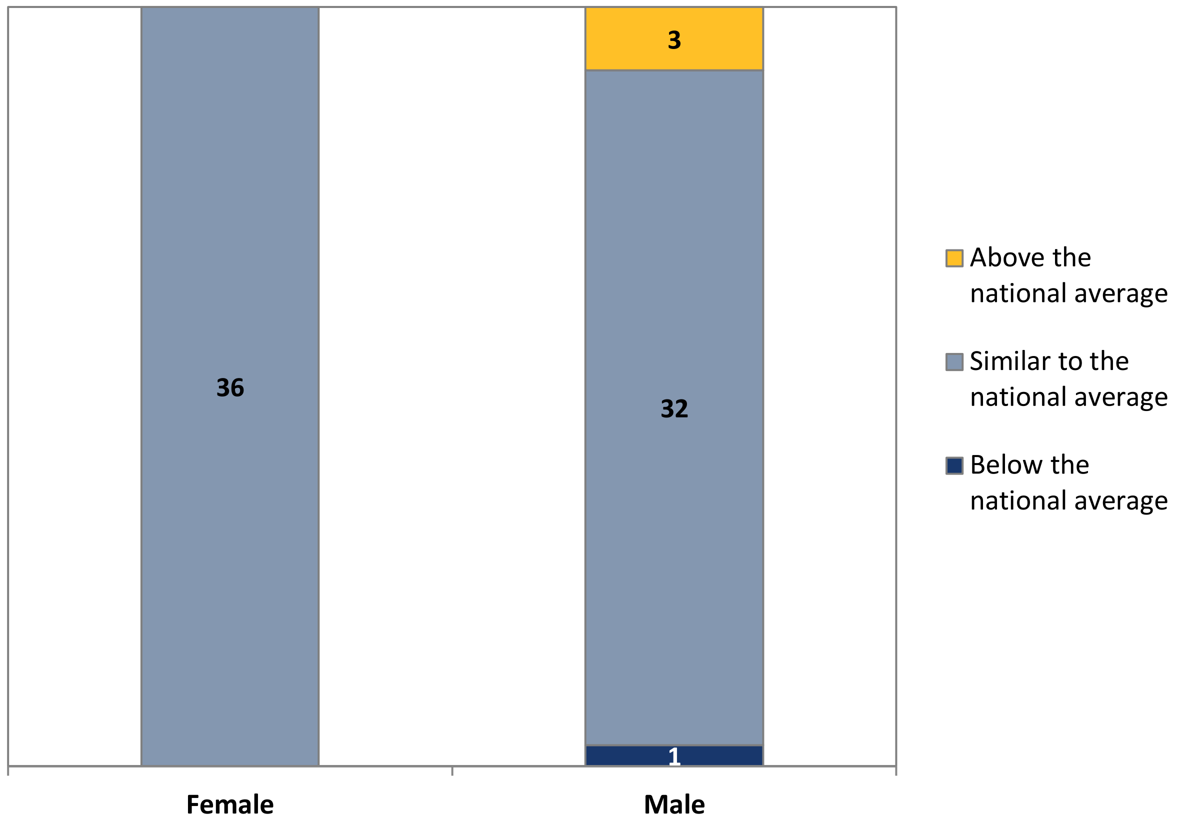
SOURCE: Data are from the 2023 MA CAHPS surveys.

Disparities

- The percentage of female MA enrollees who received the flu vaccine was **similar to** the national average for all MA enrollees.
- The percentage of male MA enrollees who received the flu vaccine was **similar to** the national average for all MA enrollees.

Disparities in Care by Sex: All Clinical Care Measures

Number of clinical care measures (out of 36) for which female and male MA enrollees had results that were above, similar to, or below the national average in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.

NOTE: When only two groups are compared, scores for the larger group—in most cases here, female MA enrollees—will always be closer to the overall (national) average than scores for the smaller group.

Each group is compared with the national average for all MA enrollees.

- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points[†] on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group received care that was below the national average. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

[†] A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

Male MA enrollees had results that were below the national average
• Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

Male MA enrollees had results that were above the national average
• Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia
• Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls
• Avoiding Use of High-Risk Medications in Older Adults

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by sex, Reporting Year 2023

— National average for all MA enrollees = 77.6

- ▲ Significantly above the national average by 3 points or more
- △ Significantly above the national average by less than 3 points
- ▽ Significantly below the national average by less than 3 points
- ▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

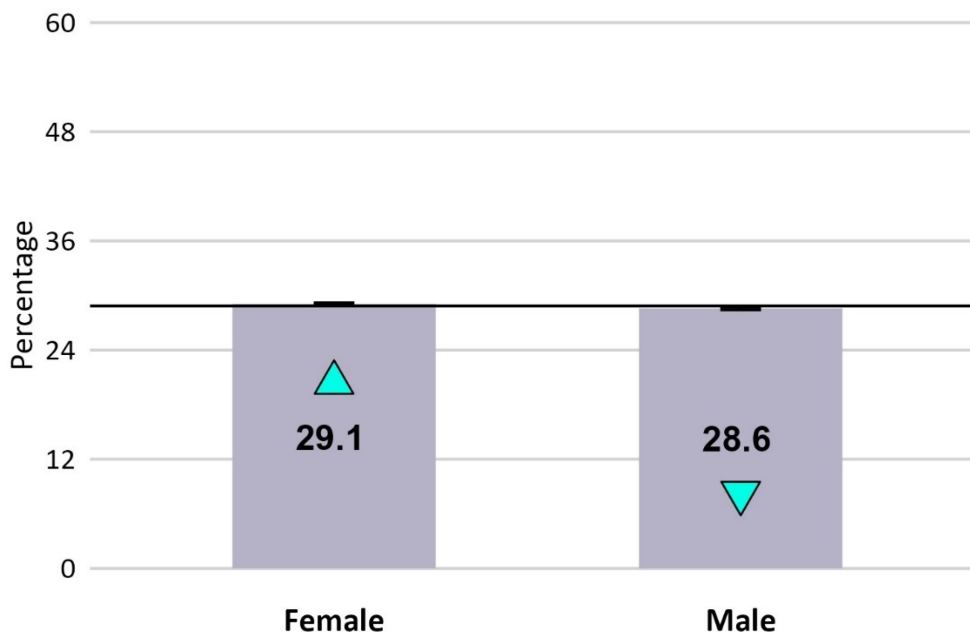
- The percentage of eligible female MA enrollees who were appropriately screened for colorectal cancer was **above** the national average for all eligible MA enrollees by less than 3 percentage points.[†]
- The percentage of eligible male MA enrollees who were appropriately screened for colorectal cancer screening was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

[†] Unlike on pp. 133–134, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by sex, Reporting Year 2023



— National average for all MA enrollees = 28.8

- ▲ Significantly above the national average by 3 points or more
- △ Significantly above the national average by less than 3 points
- ▽ Significantly below the national average by less than 3 points
- ▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of eligible female MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible male MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation—
Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by sex, Reporting Year 2023

— National average for all MA enrollees = 75.3

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

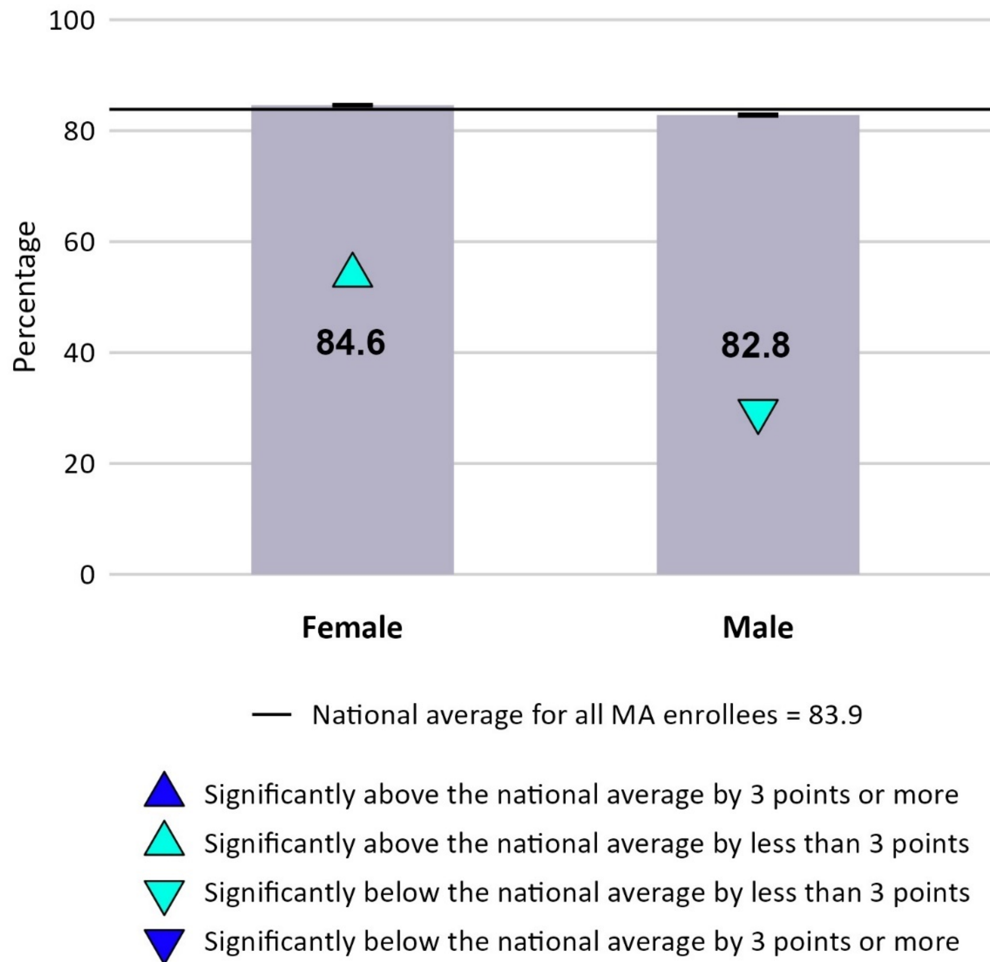
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

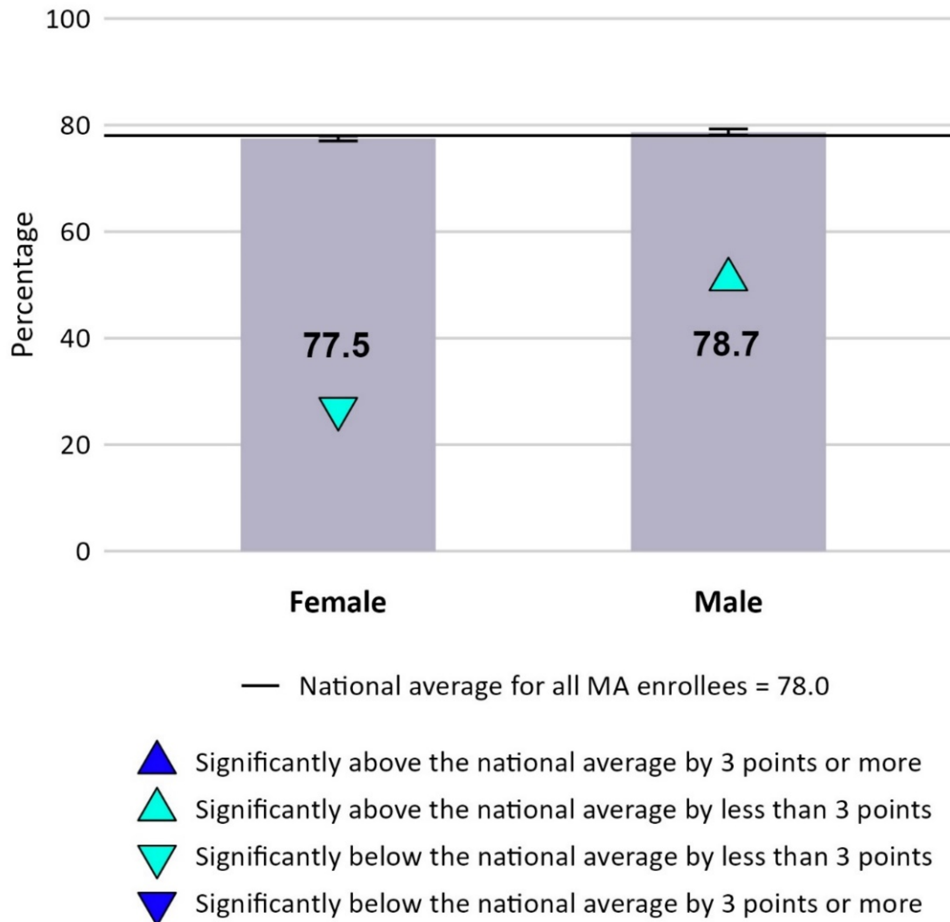
Disparities

- The percentage of eligible female MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled† during the past year, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

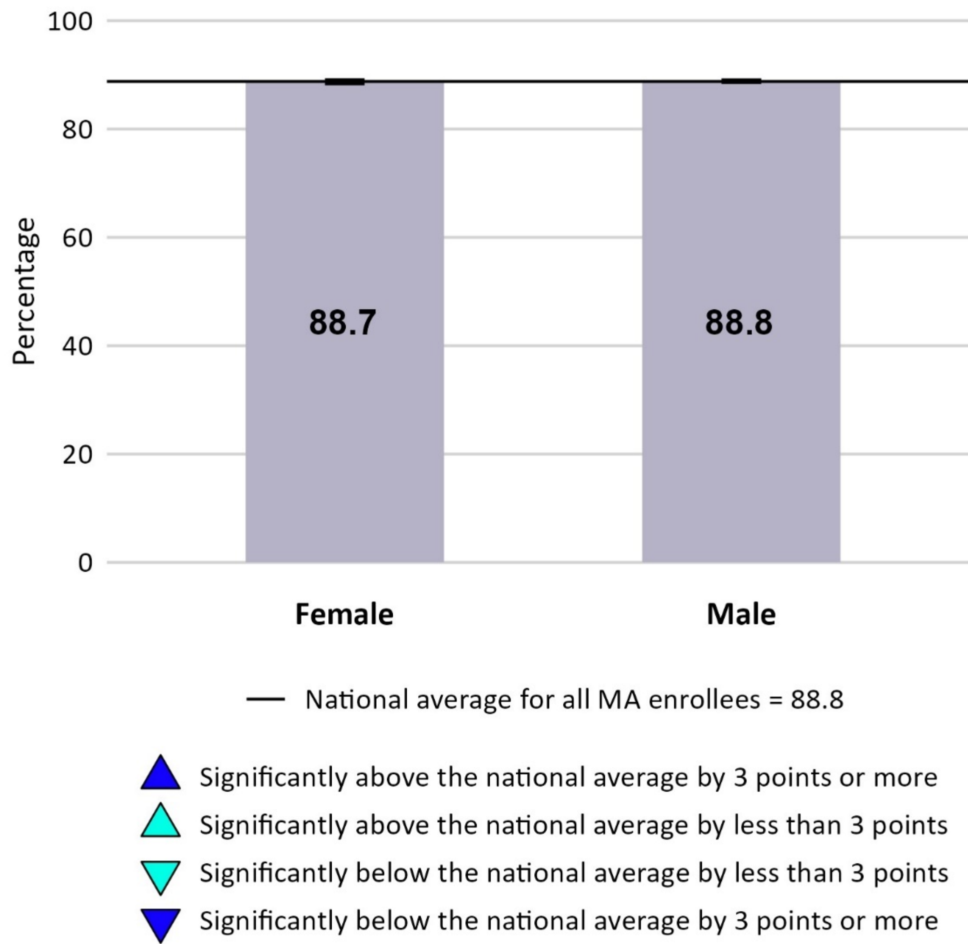
Disparities

- The percentage of eligible female MA enrollees who had their blood pressure adequately controlled was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible male MA enrollees who had their blood pressure adequately controlled was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

† Less than 140/90 for patients 18 to 59 years of age and for patients 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for patients 60 to 85 years of age without a diagnosis of diabetes.

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI) who received continuous beta-blocker treatment for six months after discharge, by sex, Reporting Year 2023



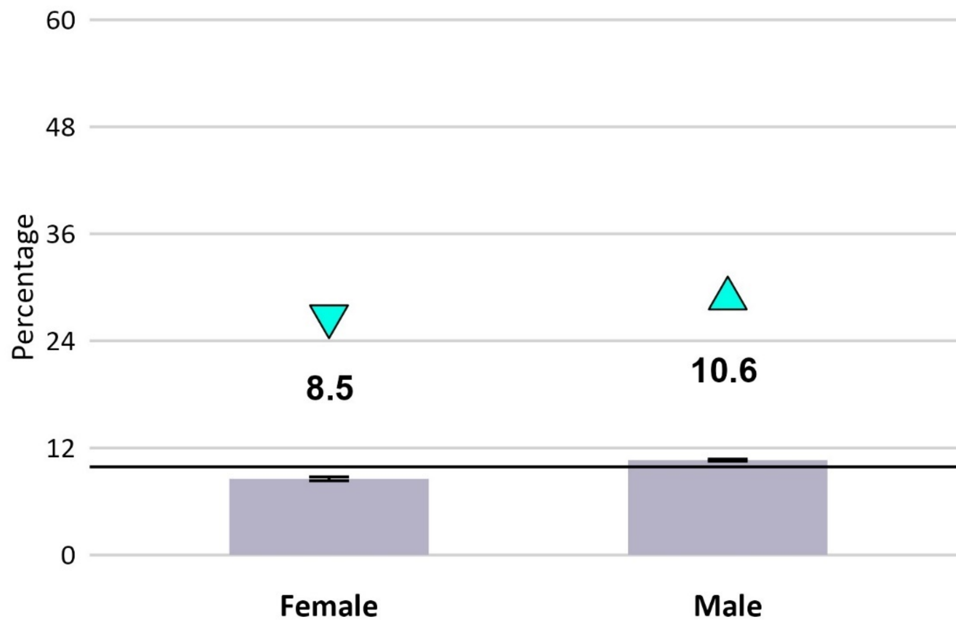
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all eligible MA enrollees.
- The percentage of eligible male MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all eligible MA enrollees.

Initiation of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older† who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event, by sex, Reporting Year 2023



— National average for all MA enrollees = 9.9

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

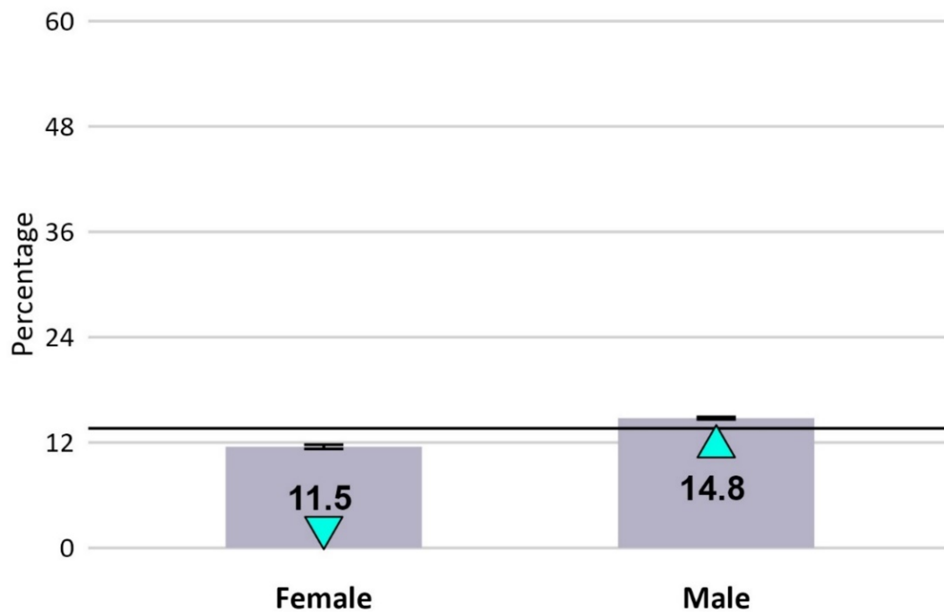
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentage of female MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.
- The percentage of male MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

Engagement of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older† who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event, by sex, Reporting Year 2023



— National average for all MA enrollees = 13.6

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

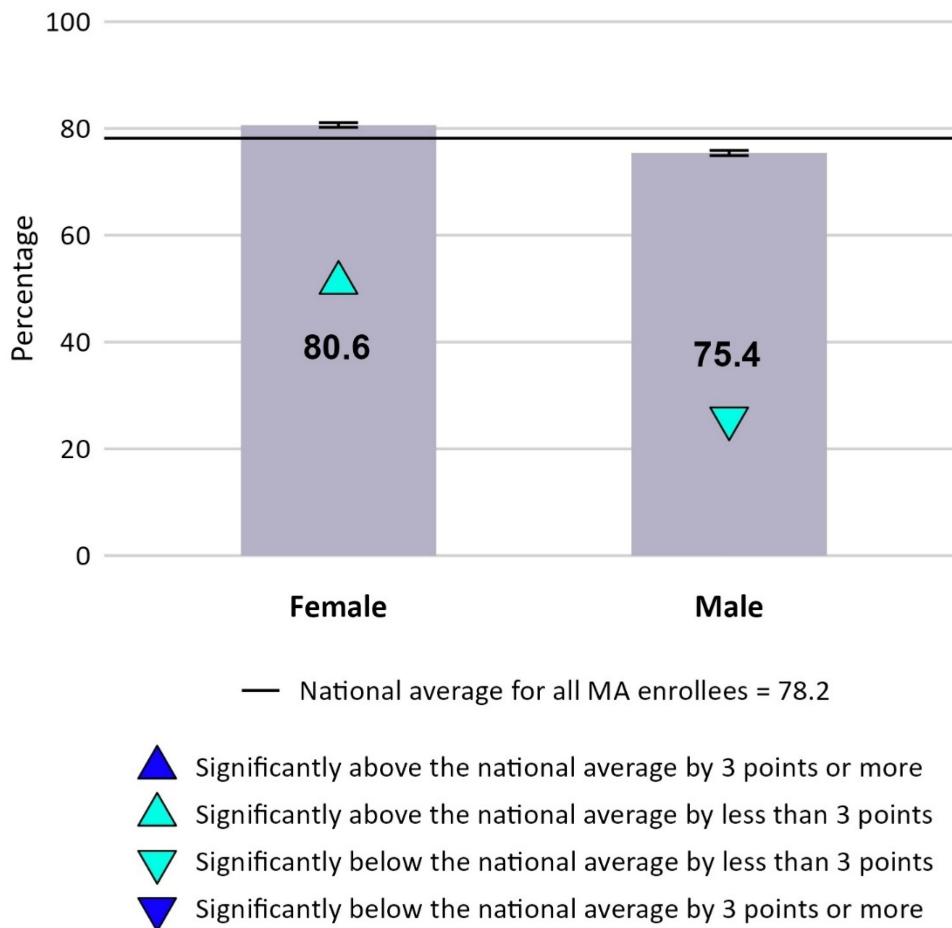
- The percentage of female MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **below** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.
- The percentage of male MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all MA enrollees who had a cardiac event by less than 3 percentage points.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Clinical Care: Diabetes

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by sex, Reporting Year 2023



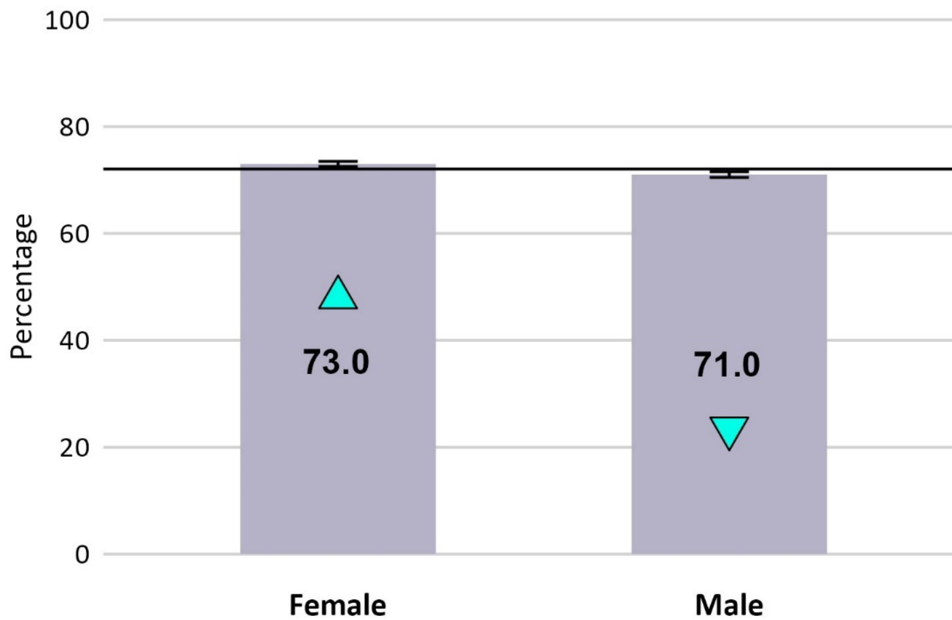
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had an eye exam in the past year was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had an eye exam in the past year was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by sex, Reporting Year 2023



— National average for all MA enrollees = 72.1

- Significantly above the national average by 3 points or more
- Significantly above the national average by less than 3 points
- Significantly below the national average by less than 3 points
- Significantly below the national average by 3 points or more

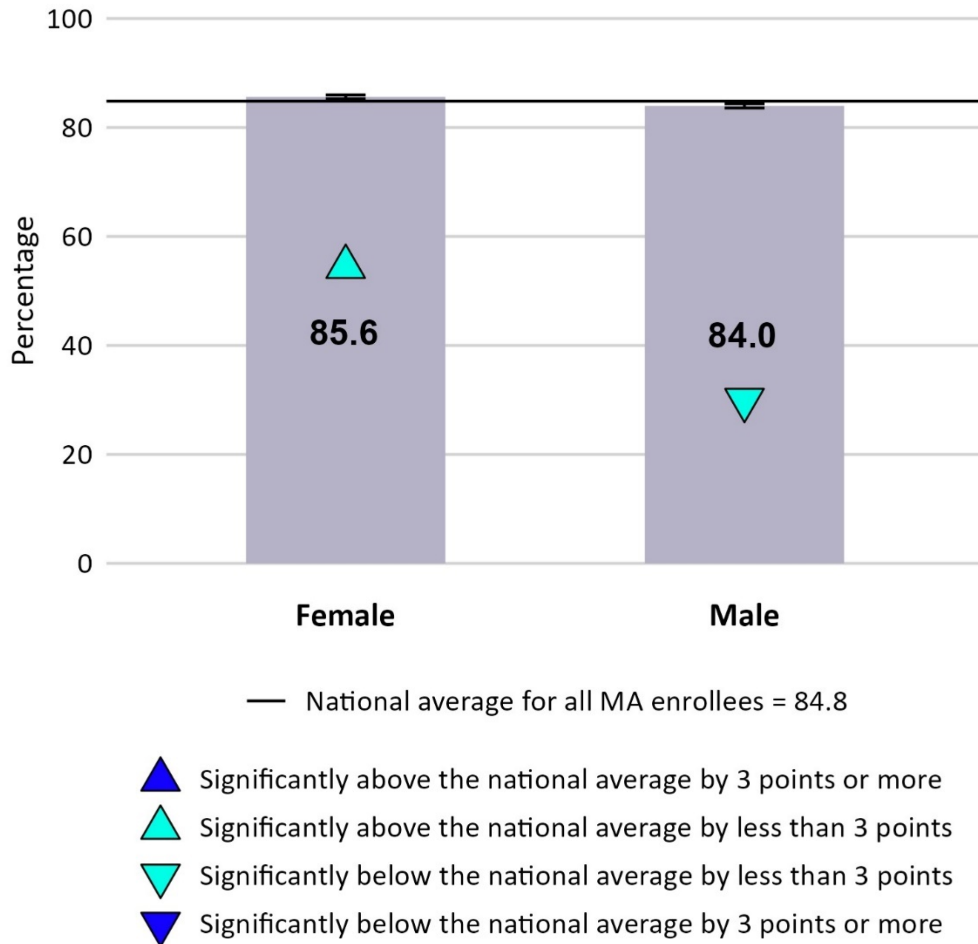
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had their blood pressure under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had their blood pressure under control was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by sex, Reporting Year 2023



— National average for all MA enrollees = 84.8

- ▲ Significantly above the national average by 3 points or more
- △ Significantly above the national average by less than 3 points
- ▽ Significantly below the national average by less than 3 points
- ▼ Significantly below the national average by 3 points or more

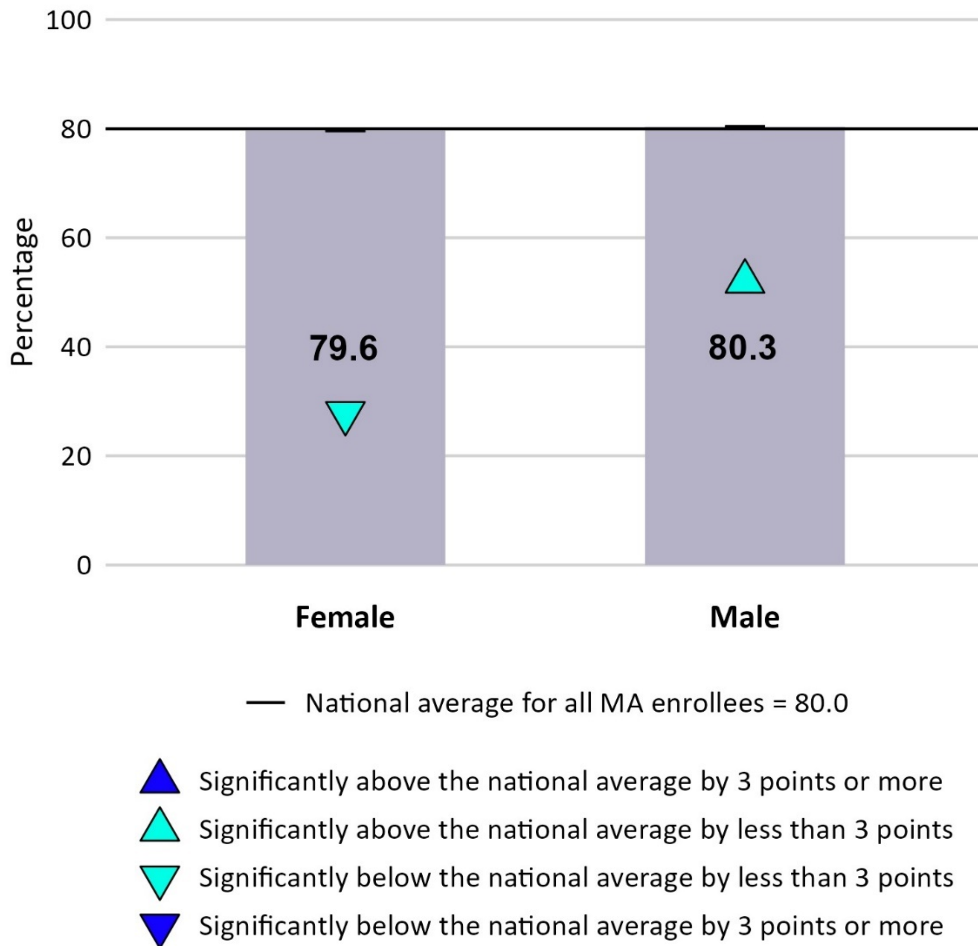
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.

Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who received statin therapy, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with diabetes who received statin therapy was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who received statin therapy was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

[†] Excludes those MA enrollees who also have clinical ASCVD.

Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who were dispensed a statin medication and remained on the medication for at least 80 percent of the treatment period, by sex, Reporting Year 2023

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

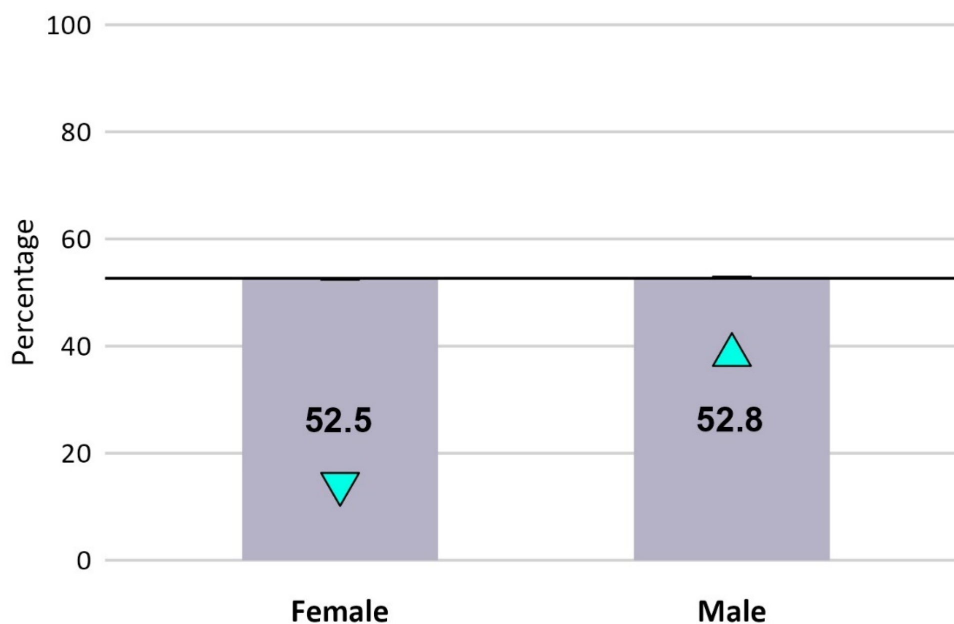
Disparities

- The percentage of female MA enrollees with diabetes who had proper statin medication adherence was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who had proper statin medication adherence was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

[†] Excludes those MA enrollees who also have clinical ASCVD.

Kidney Health Evaluation for Patients with Diabetes

Percentage of MA enrollees aged 18 to 85 years with diabetes (type 1 and type 2) who received an annual kidney health evaluation,[†] by sex, Reporting Year 2023



— National average for all MA enrollees = 52.7

- Significantly above the national average by 3 points or more
- Significantly above the national average by less than 3 points
- Significantly below the national average by less than 3 points
- Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

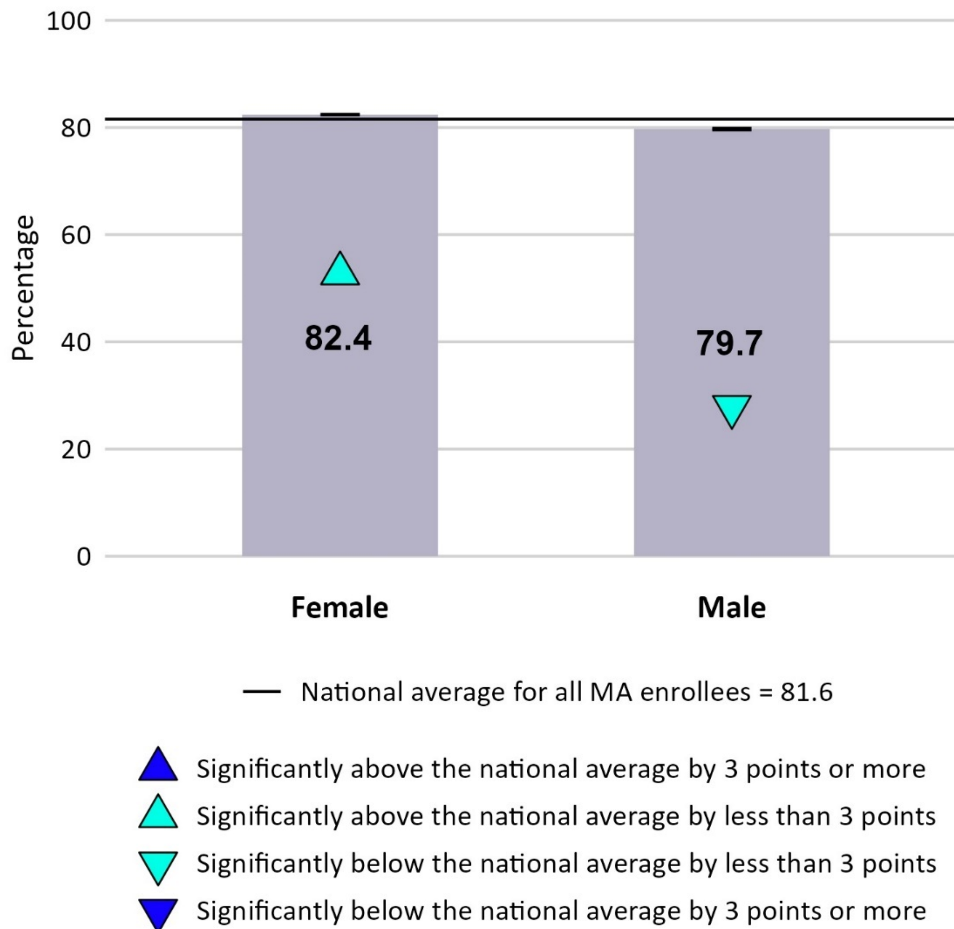
- The percentage of female MA enrollees with diabetes who received an annual kidney health evaluation was **below** the national average for all MA enrollees with diabetes by less than 3 percentage points.
- The percentage of male MA enrollees with diabetes who received an annual kidney health evaluation was **above** the national average for all MA enrollees with diabetes by less than 3 percentage points.

[†] Includes both an estimated glomerular filtration rate and a urine albumin-creatinine ratio.

Clinical Care: Behavioral Health

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by sex, Reporting Year 2023



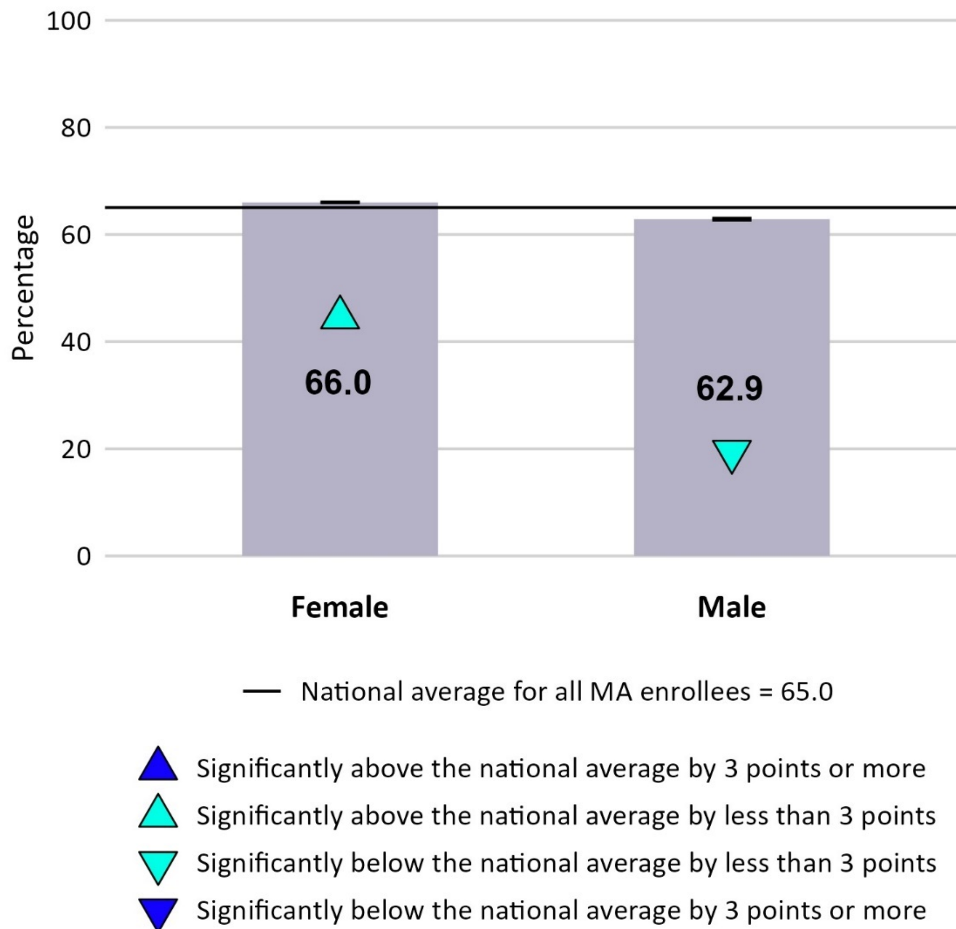
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 180 days, by sex, Reporting Year 2023



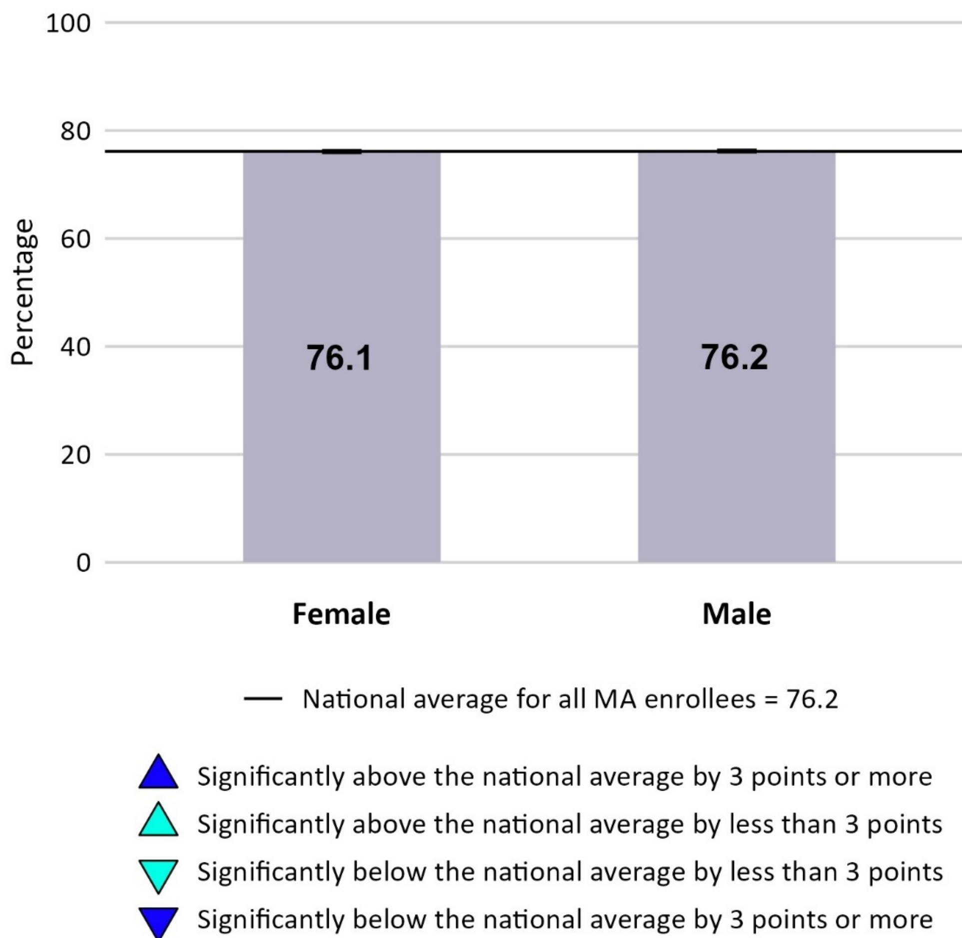
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of eligible female MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of eligible male MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

Adherence to Antipsychotic Medications for People with Schizophrenia

Percentage of MA enrollees aged 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period, by sex, Reporting Year 2023



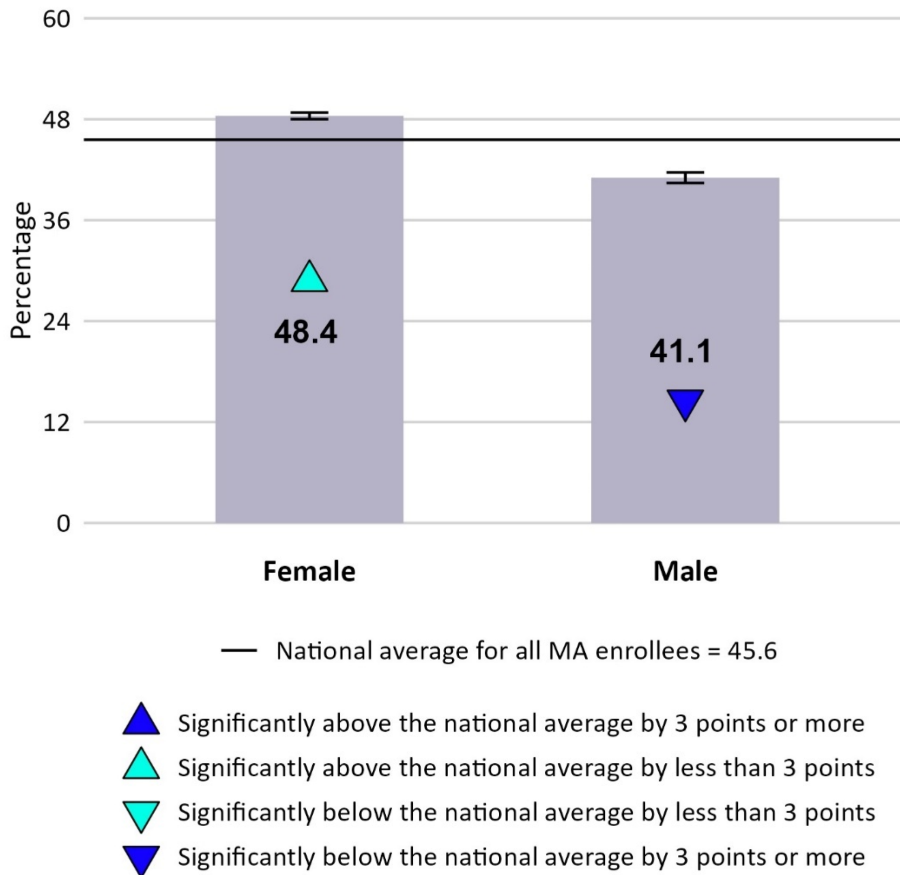
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **similar to** the national average for all MA enrollees with schizophrenia or schizoaffective disorder.
- The percentage of male MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **similar to** the national average for all MA enrollees with schizophrenia or schizoaffective disorder.

Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

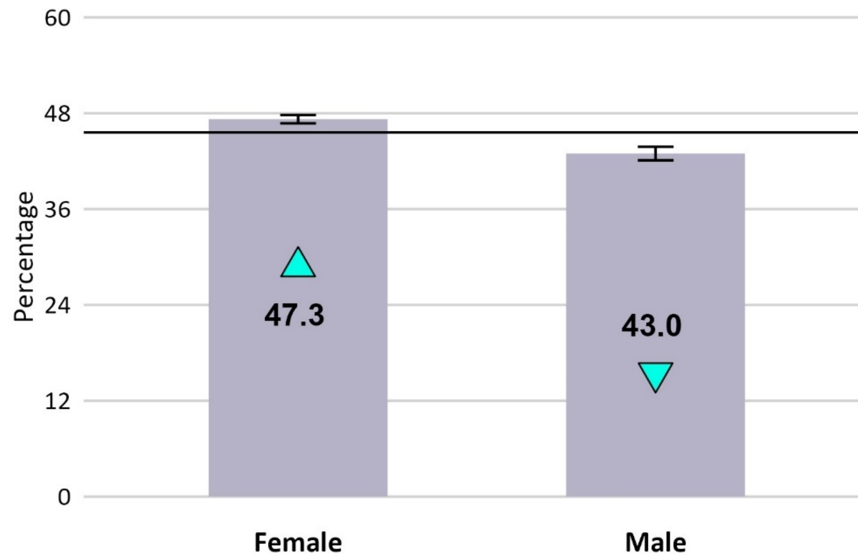
- The percentage of older adult female MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible older adult MA enrollees by more than 3 percentage points.

---

† Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older† who had an ED visit for selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of the ED visit, by sex, Reporting Year 2023



— National average for all MA enrollees = 45.6

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

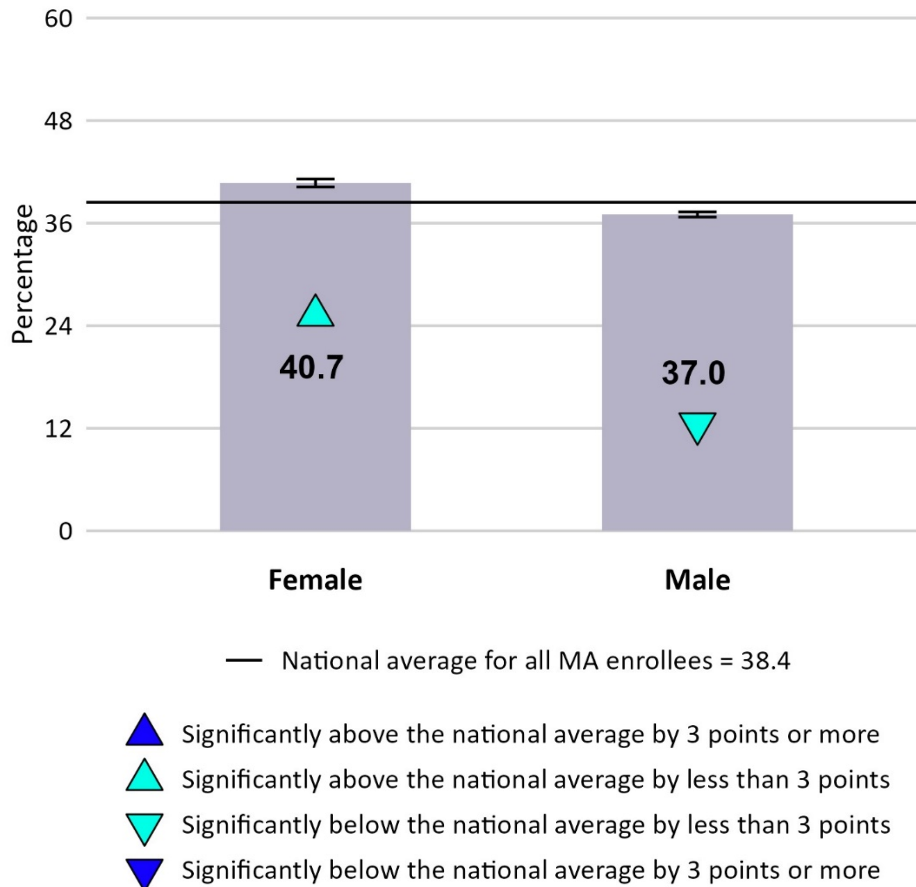
Disparities

- The percentage of older adult female MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

† Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)

Percentage of MA enrollees aged 18 years and older† who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

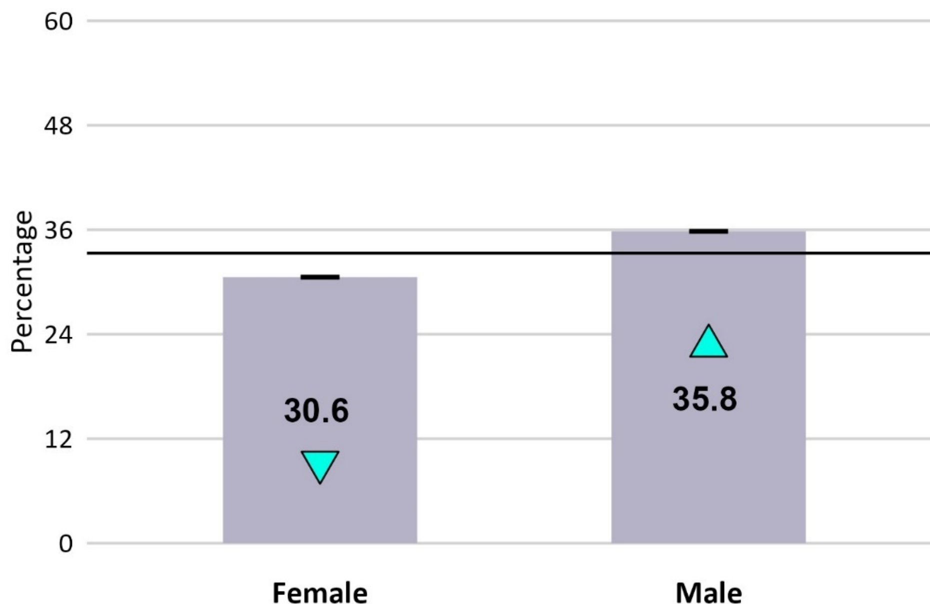
<u>Disparities</u>

- The percentage of female MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of male MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible MA enrollees by less than 3 percentage points.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Initiation of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated[‡] treatment within 14 days of the diagnosis, by sex, Reporting Year 2023



— National average for all MA enrollees = 33.3

- ▲ Significantly above the national average by 3 points or more
- △ Significantly above the national average by less than 3 points
- ▽ Significantly below the national average by less than 3 points
- ▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

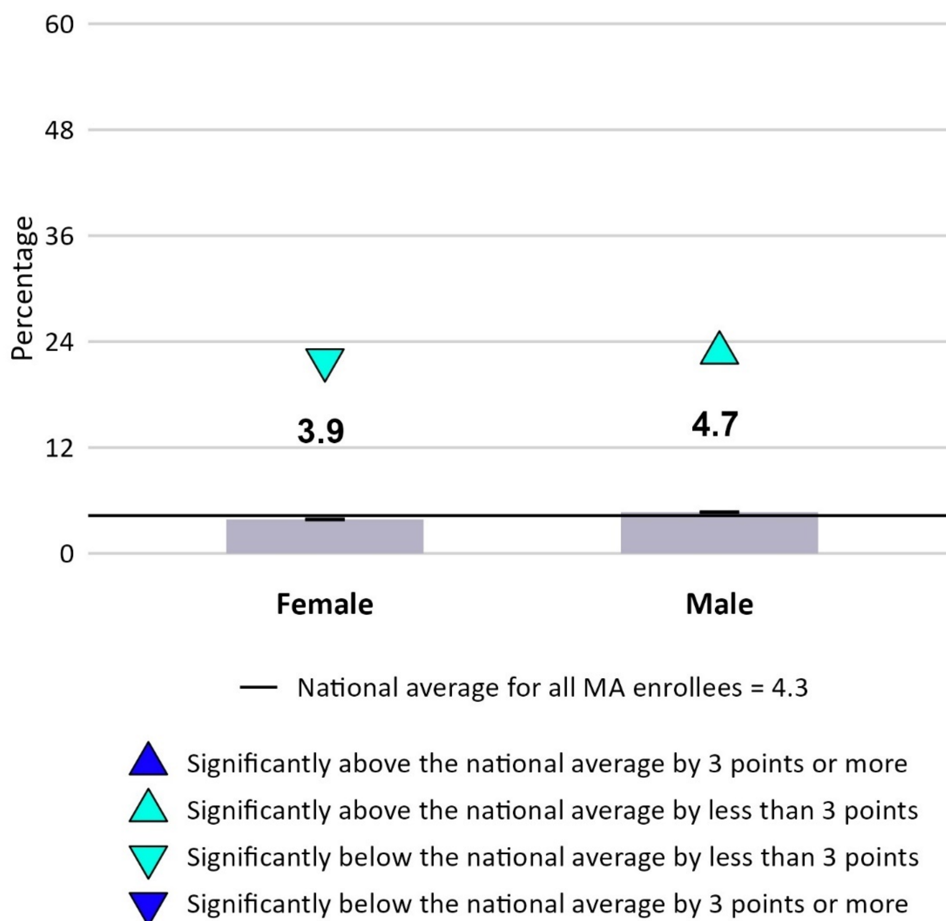
- The percentage of female MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of male MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

[‡] Initiation might occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Engagement of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older[†] with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

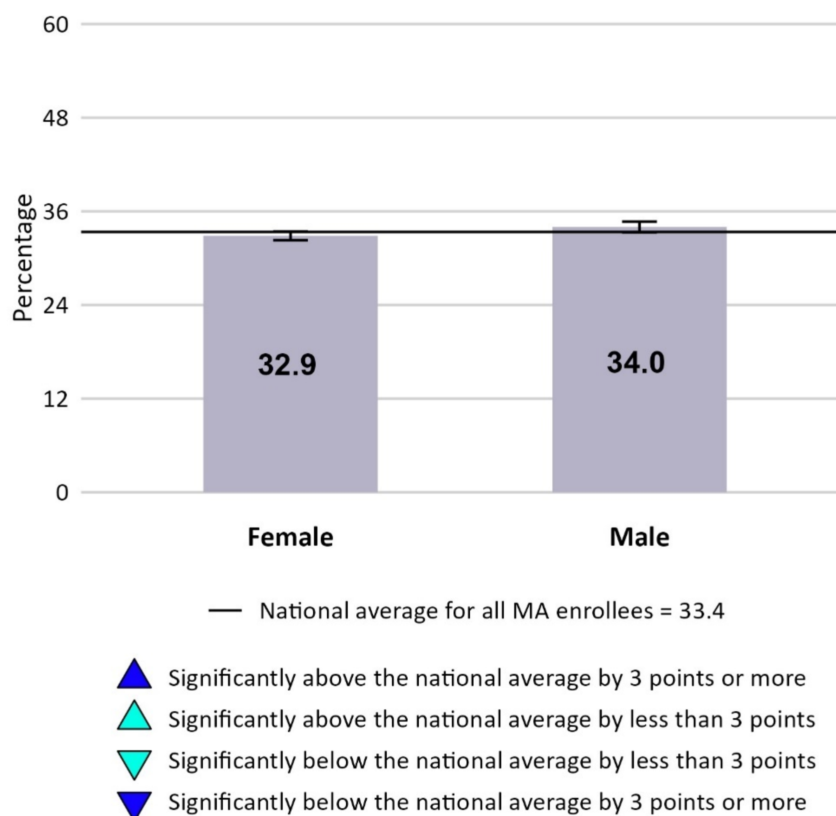
- The percentage of female MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **below** the national average for all eligible MA enrollees by less than 3 percentage points.
- The percentage of male MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **above** the national average for all eligible MA enrollees by less than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTE: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

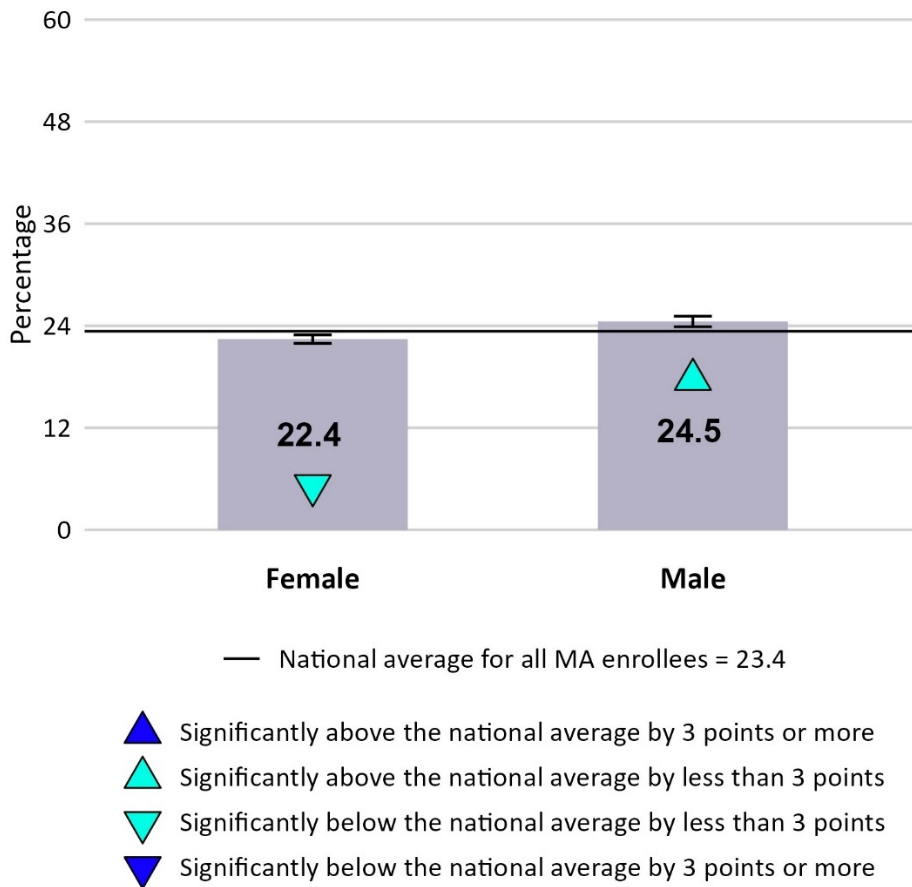
Disparities

- The percentage of older adult female MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult male MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average for all eligible older adult MA enrollees.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by sex, Reporting Year 2023



— National average for all MA enrollees = 23.4

- Significantly above the national average by 3 points or more
- Significantly above the national average by less than 3 points
- Significantly below the national average by less than 3 points
- Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

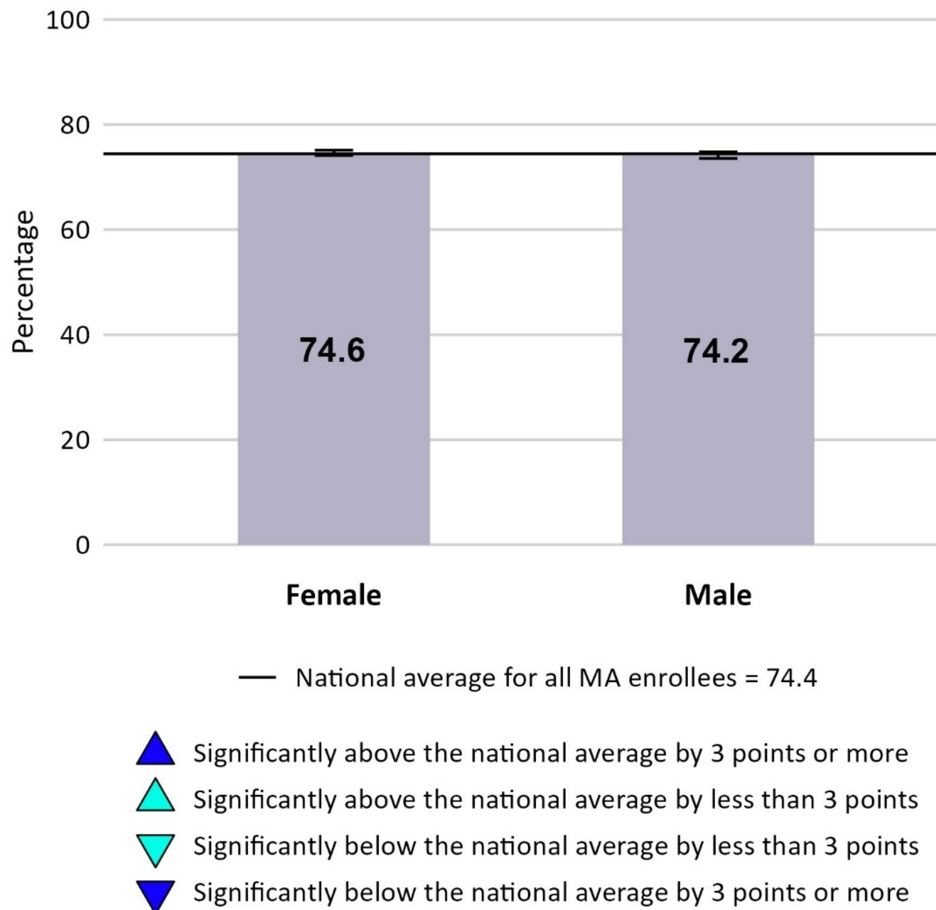
Disparities

- The percentage of older adult female MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

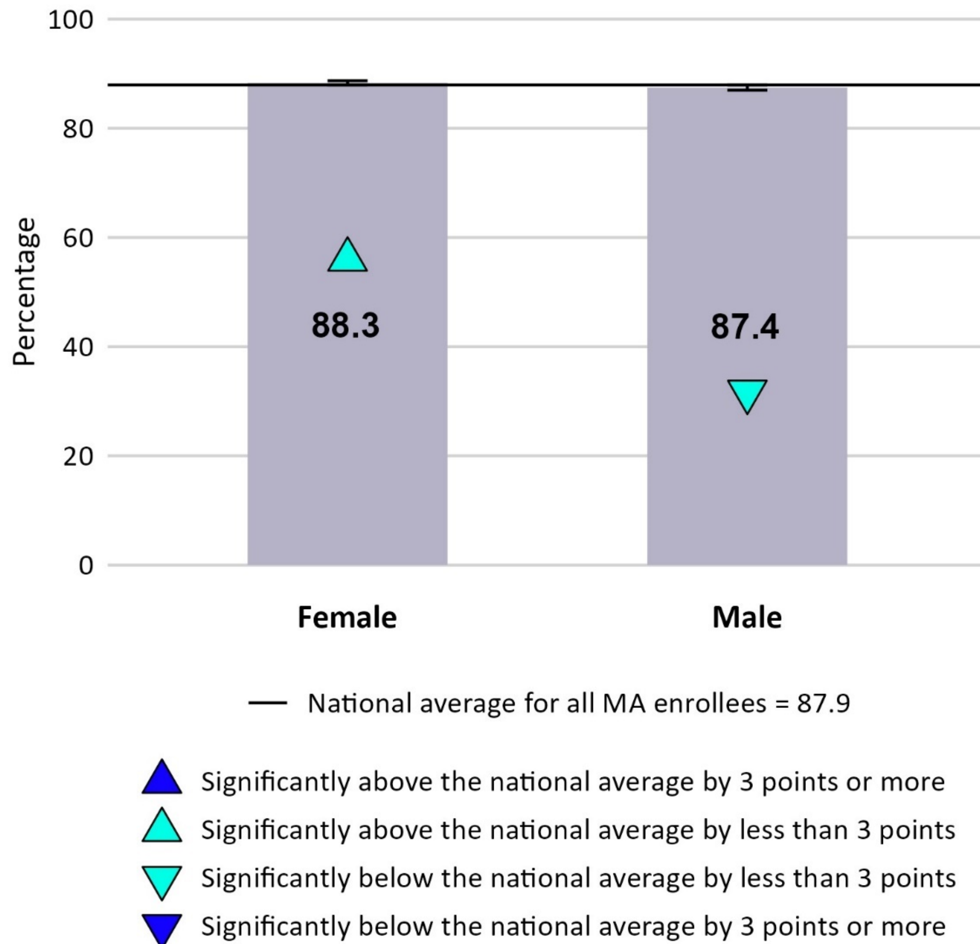
Disparities

- The percentage of older adult female MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.
- The percentage of older adult male MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult MA enrollees.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth services) was provided within 30 days of discharge, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

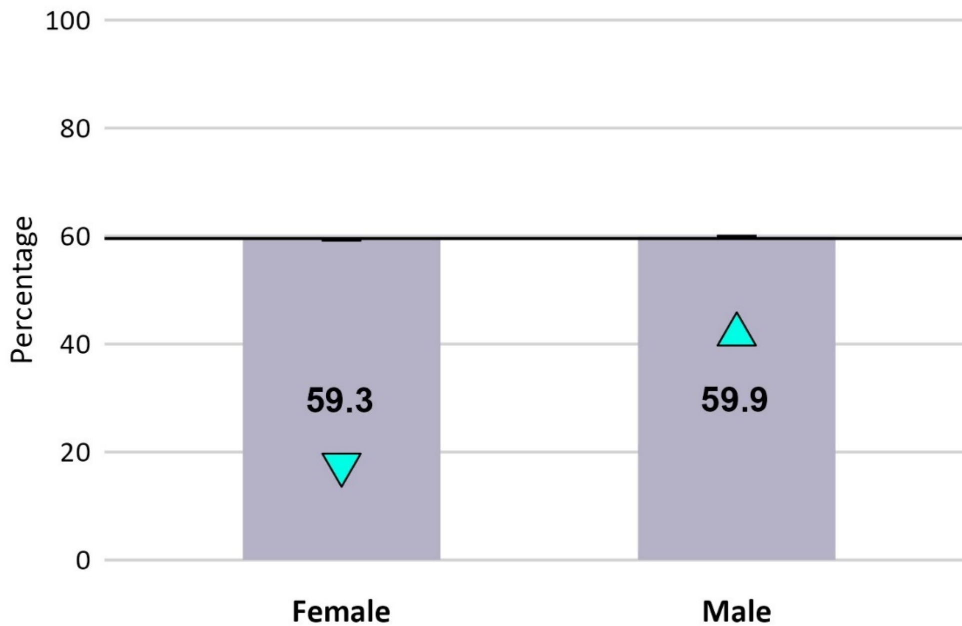
Disparities

- The percentage of older adult female MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Percentage of MA enrollees aged 65 years and older[†] with multiple high-risk chronic conditions[‡] who received follow-up care within seven days of an ED visit, by sex, Reporting Year 2023



— National average for all MA enrollees = 59.5

- ▲ Significantly above the national average by 3 points or more
- △ Significantly above the national average by less than 3 points
- ▽ Significantly below the national average by less than 3 points
- ▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of older adult female MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

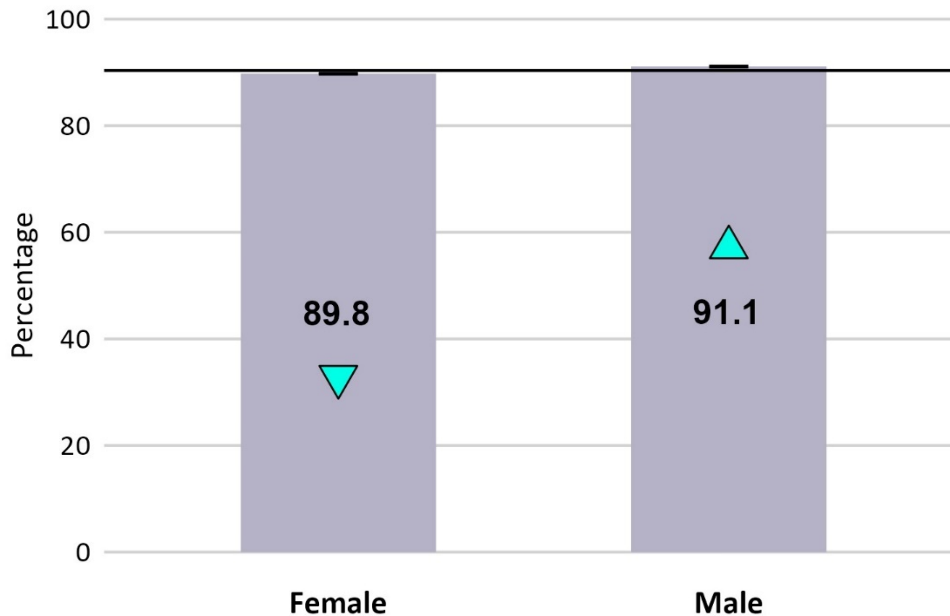
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

[‡] Conditions include COPD and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, AMI, atrial fibrillation, and stroke and transient ischemic attack.

Clinical Care: Overuse and Appropriate Use of Medication

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,† by sex, Reporting Year 2023



— National average for all MA enrollees = 90.4

- ▲ (blue) Significantly above the national average by 3 points or more
- ▲ (teal) Significantly above the national average by less than 3 points
- ▼ (teal) Significantly below the national average by less than 3 points
- ▼ (blue) Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

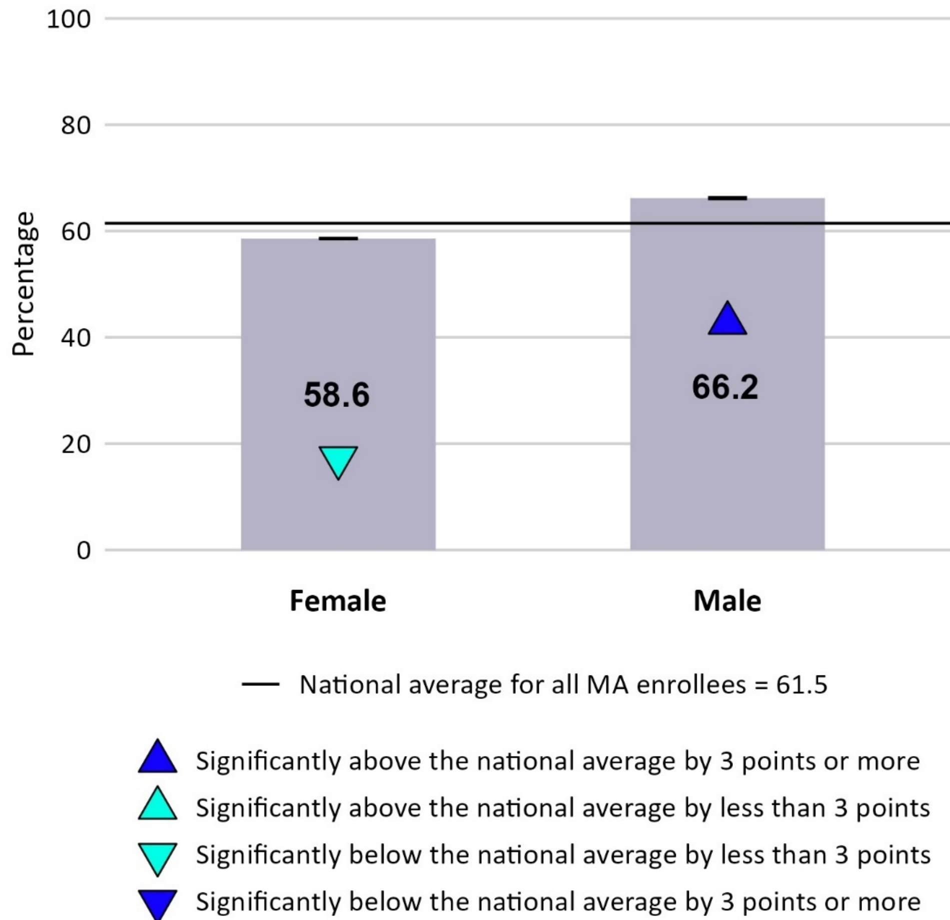
Disparities

- The percentage of older adult female MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by less than 3 percentage points.

† This includes cyclooxygenase-2 selective nonsteroidal anti-inflammatory drugs (NSAIDs) or nonaspirin NSAIDs.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,† by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

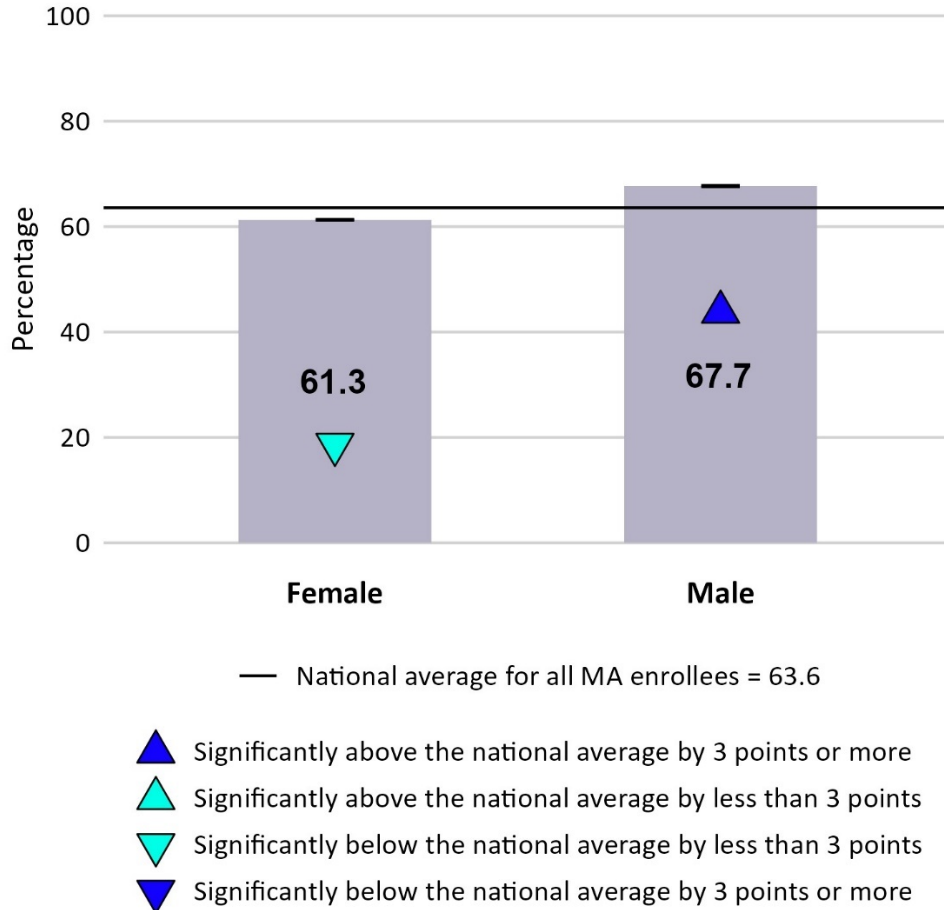
Disparities

- The percentage of older adult female MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.

† This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,† by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

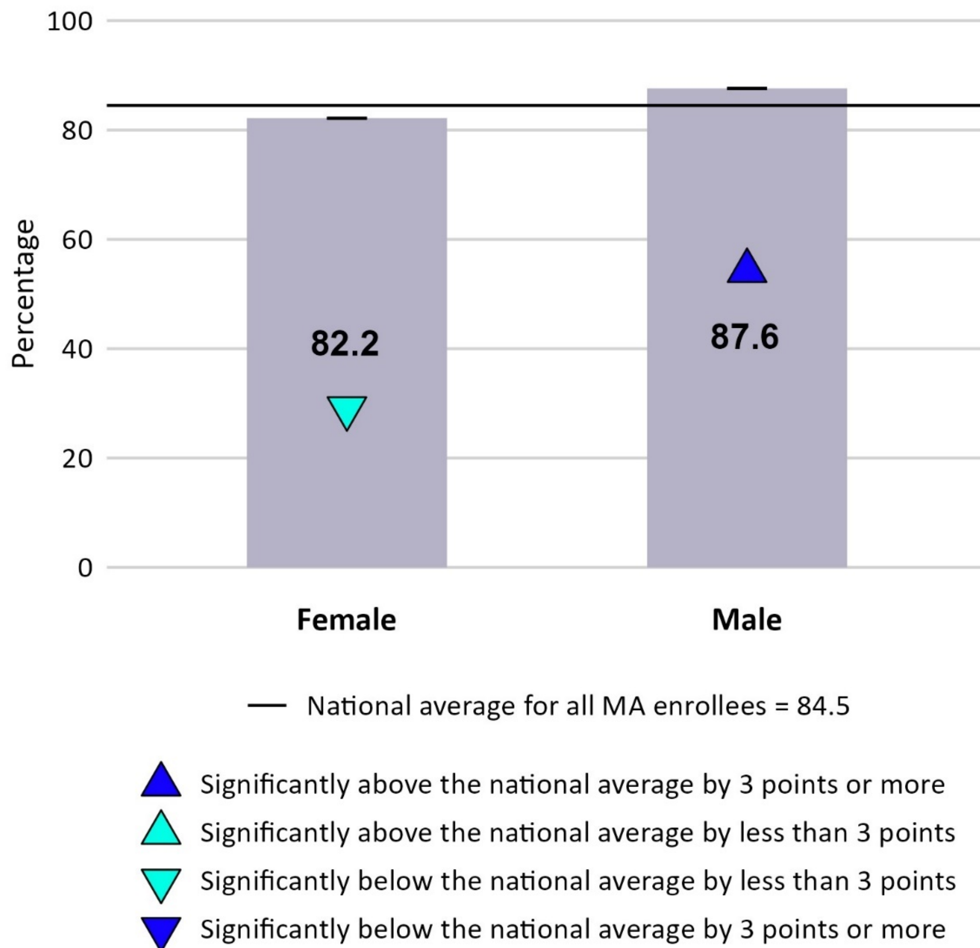
- The percentage of older adult female MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.

---

† This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake inhibitors, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Avoiding Use of High-Risk Medications in Older Adults

Percentage of MA enrollees aged 65 years and older who were not prescribed two or more high-risk medications from the same drug class in the past year, by sex, Reporting Year 2023



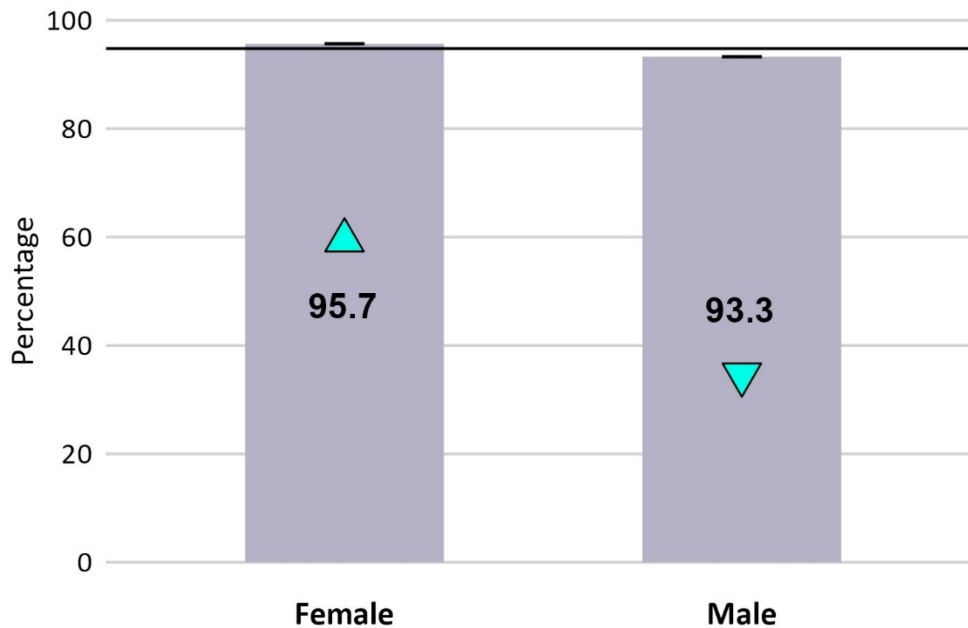
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of older adult female MA enrollees for whom use of high-risk medications was avoided was **below** the national average for all eligible older adult MA enrollees by less than 3 percentage points.
- The percentage of older adult male MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all eligible older adult MA enrollees by more than 3 percentage points.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage† for more than 14 days in the past year, by sex, Reporting Year 2023



— National average for all MA enrollees = 94.8

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

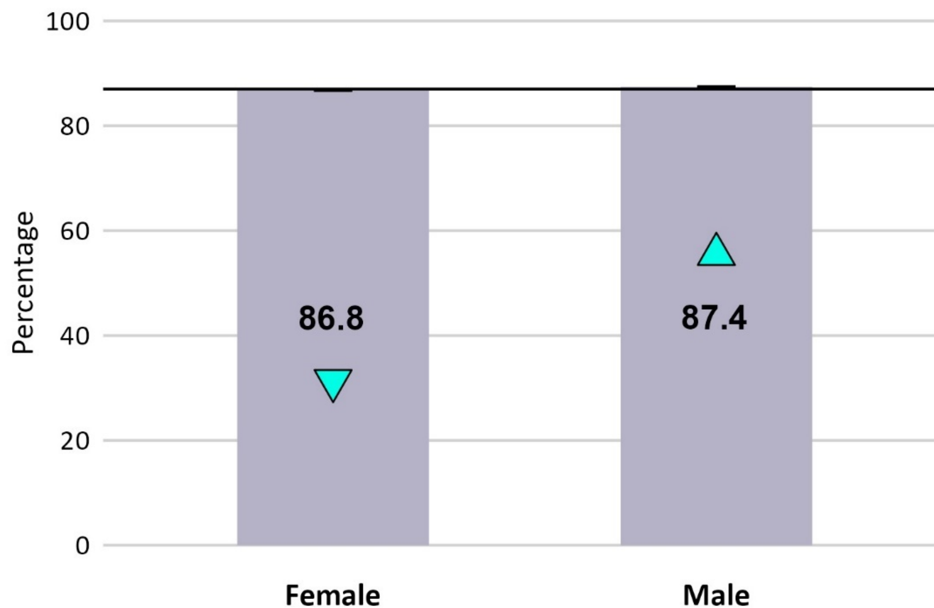
Disparities

- The percentage of female MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of male MA enrollees for whom use of opioids at a high dosage was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.

† Average morphine equivalent dose ≥ 90 mg.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by sex, Reporting Year 2023



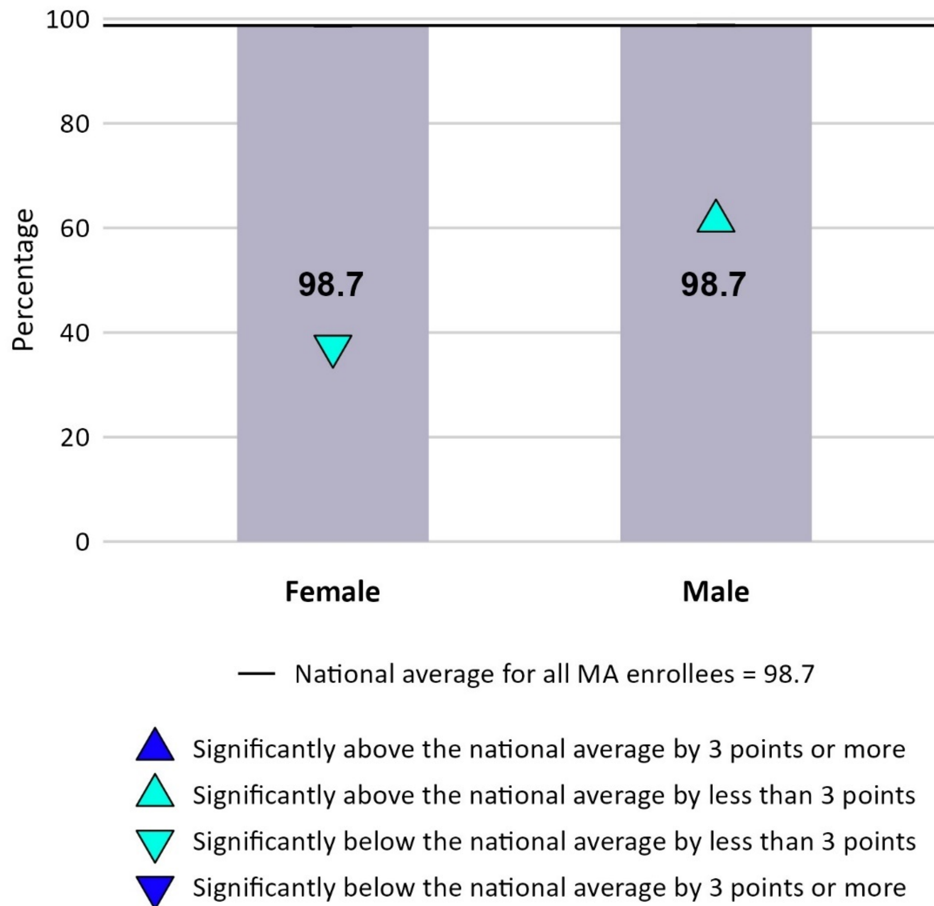
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

Disparities

- The percentage of female MA enrollees for whom use of opioids from multiple prescribers was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of male MA enrollees for whom use of opioids from multiple prescribers was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

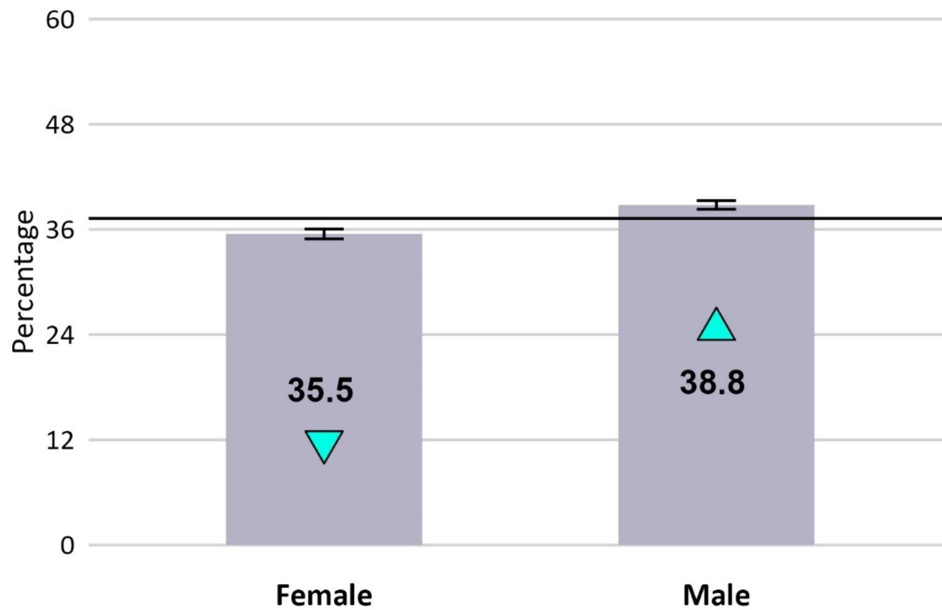
Disparities

- The percentage of female MA enrollees for whom use of opioids from multiple pharmacies was avoided was **below** the national average for all MA enrollees by less than 3 percentage points.[†]
- The percentage of male MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all MA enrollees by less than 3 percentage points.[†]

[†] Prior to rounding.

Pharmacotherapy for Opioid Use Disorder

Percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees aged 18 years and older[†] that continued for at least 180 days, by sex, Reporting Year 2023



— National average for all MA enrollees = 37.3

▲ Significantly above the national average by 3 points or more
△ Significantly above the national average by less than 3 points
▽ Significantly below the national average by less than 3 points
▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

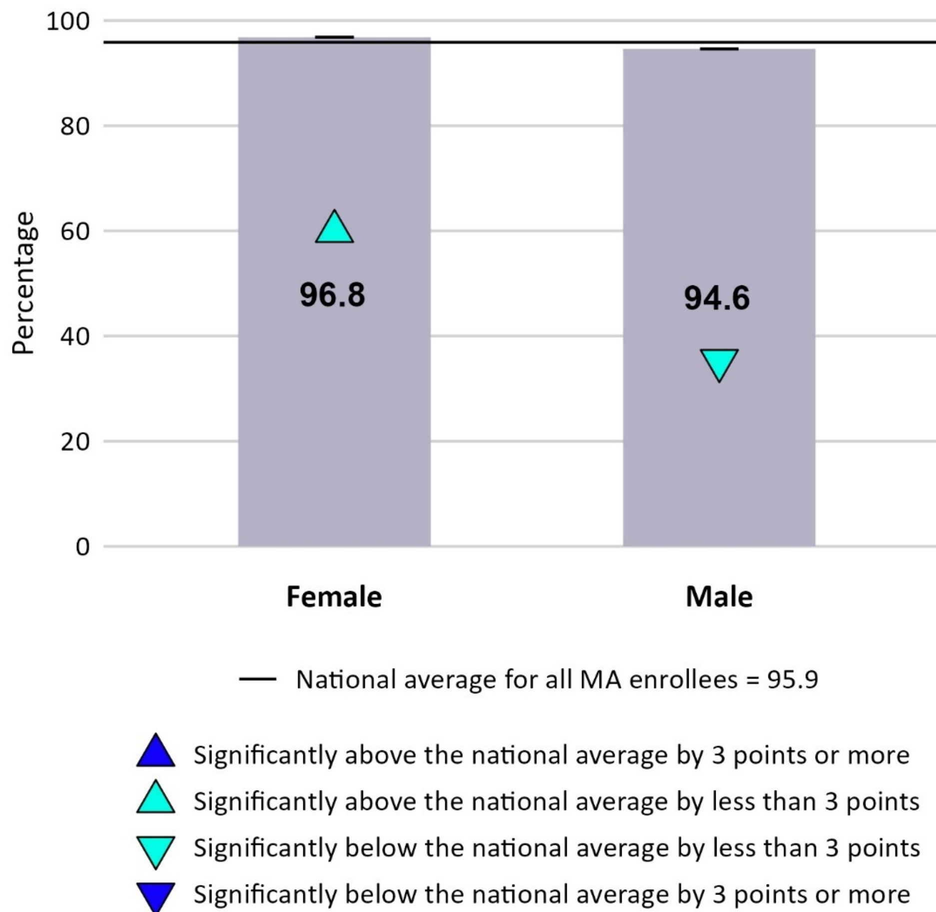
- The percentage of opioid use disorder pharmacotherapy treatment events among female MA enrollees that continued for at least 180 days was **below** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of opioid use disorder pharmacotherapy treatment events among male MA enrollees that continued for at least 180 days was **above** the national average for all MA enrollees by less than 3 percentage points.

[†] Although the lower-bound age cutoff for this HEDIS measure is 16 years old, the data used in this report are limited to adults.

Clinical Care: Access to and Availability of Care

Adult Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 20 years and older who had an ambulatory or preventive care visit in the past year, by sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

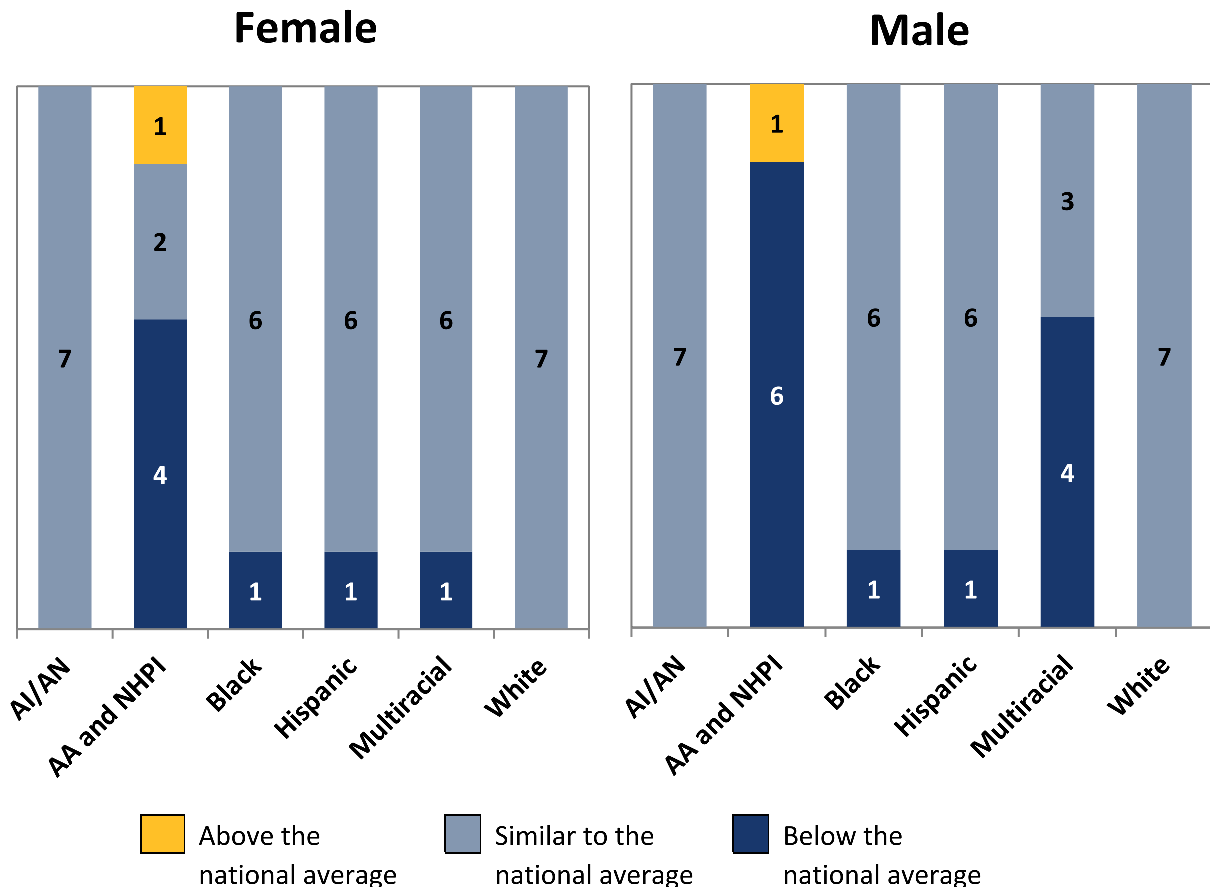
Disparities

- The percentage of female MA enrollees who had an ambulatory or preventive care visit in the past year was **above** the national average for all MA enrollees by less than 3 percentage points.
- The percentage of male MA enrollees who had an ambulatory or preventive care visit in the past year was **below** the national average for all MA enrollees by less than 3 percentage points.

Appendix C: Disparities in Health Care in Medicare Advantage by Race and Ethnicity Within Sex

Racial and Ethnic Disparities in Care by Sex: All Patient Experience Measures

Number of patient experience measures (out of 7) for which female or male MA enrollees of selected racial and ethnic groups reported experiences that were above, similar to, or below the national average for all female or male MA enrollees in 2023



SOURCE: This chart summarizes data from all MA enrollees nationwide who participated in the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Within sex, each racial or ethnic group is compared with the national average for all female/male MA enrollees.

- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points[†] on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group received care that was below the national average. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

[†] A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

Female AA and NHPI MA enrollees had results that were below the national average for all female MA enrollees
• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service • Getting Needed Prescription Drugs

Female AA and NHPI MA enrollees had results that were above the national average for all female MA enrollees
• Annual Flu Vaccine

Female Black MA enrollees had results that were below the national average for all female MA enrollees
• Annual Flu Vaccine

Female Hispanic MA enrollees had results that were below the national average for all female MA enrollees
• Getting Appointments and Care Quickly

Female Multiracial MA enrollees had results that were below the national average for all female MA enrollees
• Getting Needed Prescription Drugs

Male AA and NHPI MA enrollees had results that were below the national average for all male MA enrollees
• Getting Needed Care • Getting Appointments and Care Quickly • Customer Service • Doctors Who Communicate Well • Care Coordination • Getting Needed Prescription Drugs

Male AA and NHPI MA enrollees had results that were above the national average for all male MA enrollees
• Annual Flu Vaccine

Male Black MA enrollees had results that were below the national average for all male MA enrollees
• Annual Flu Vaccine

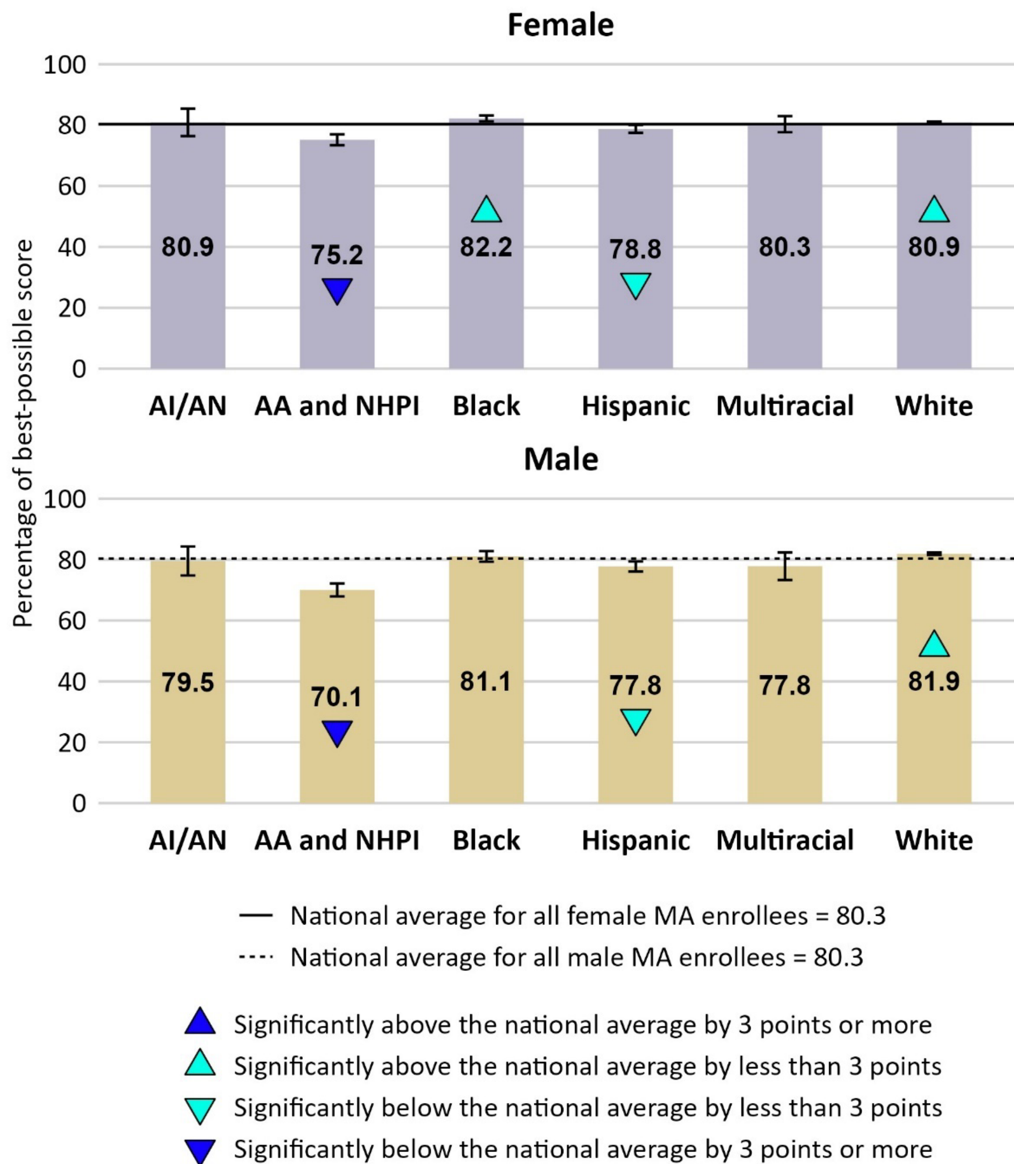
Male Hispanic MA enrollees had results that were below the national average for all male MA enrollees
• Getting Appointments and Care Quickly

Male Multiracial MA enrollees had results that were below the national average for all male MA enrollees
• Doctors Who Communicate Well • Care Coordination • Getting Needed Prescription Drugs • Annual Flu Vaccine

Patient Experience

Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,[†] by race and ethnicity within sex, 2023



— National average for all female MA enrollees = 80.3

---- National average for all male MA enrollees = 80.3

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Data are from the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

[†] This includes how often in the last six months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

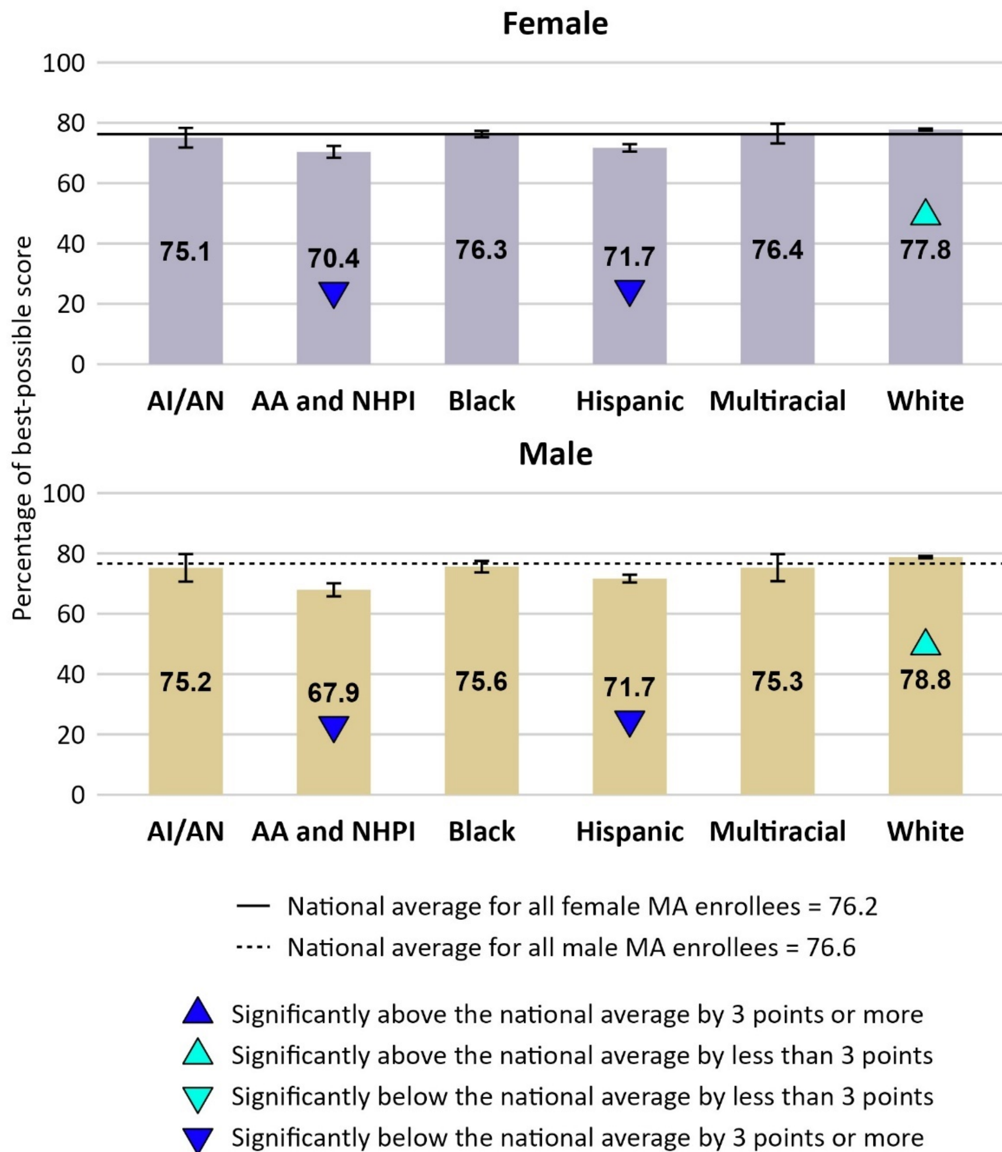
Disparities

- Female AI/AN and Multiracial MA enrollees reported experiences with getting needed care that were **similar to** the national average for all female MA enrollees. Female AA and NHPI enrollees reported experiences with getting needed care that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female Black and White MA enrollees each reported experiences with getting needed care that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.[§] Female Hispanic MA enrollees reported experiences with getting needed care that were **below** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.
- Male AI/AN, Black, and Multiracial MA enrollees each reported experiences with getting needed care that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with getting needed care that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Hispanic MA enrollees reported experiences with getting needed care that were **below** the national average for all male MA enrollees by less than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with getting needed care that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

[§] Unlike on pp. 172–174, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity within sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

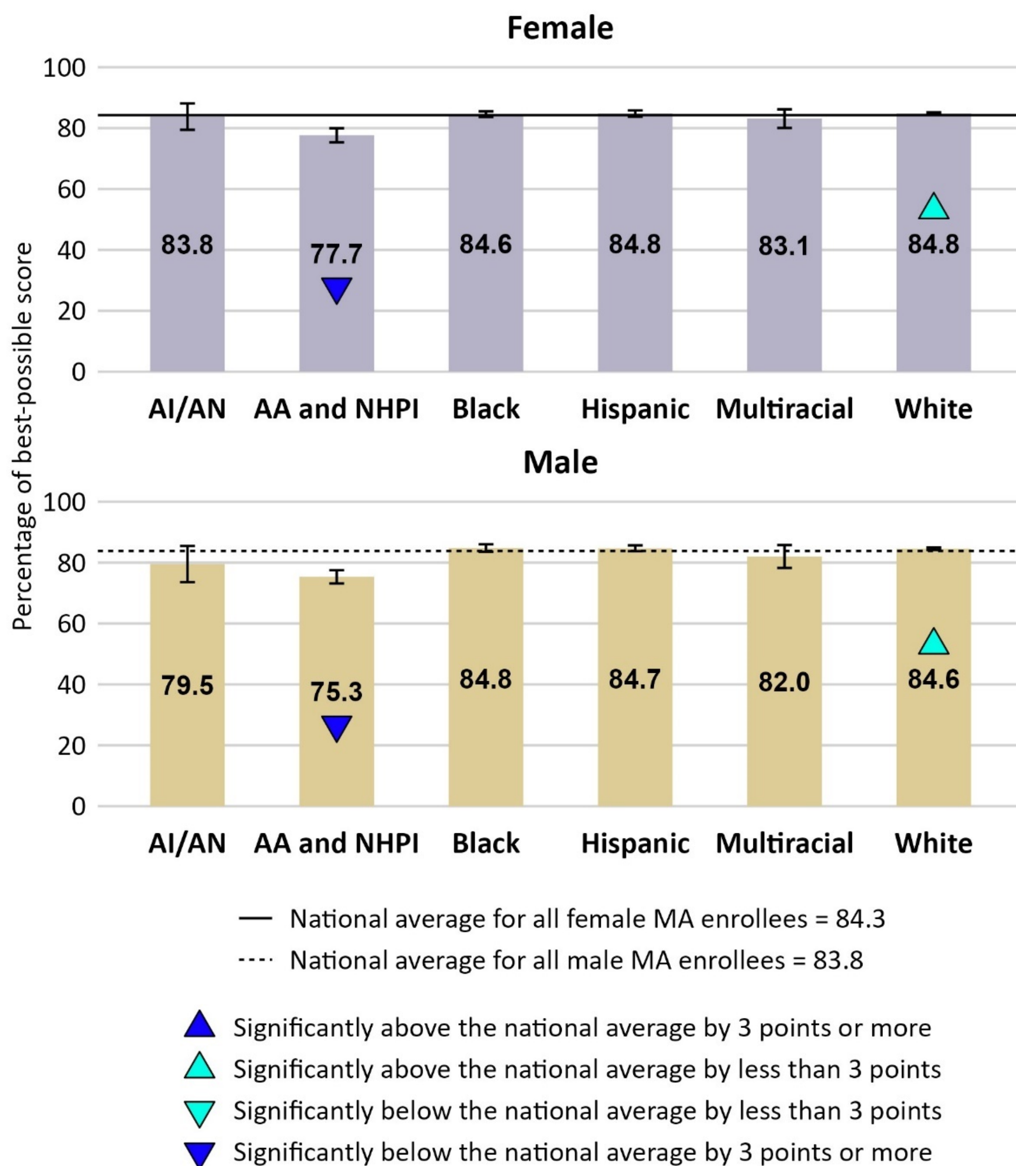
† This includes how often in the last six months patients got care that was needed right away, as well as how easy it was to get appointments for checkups and routine care.

Disparities

- Female AI/AN, Black, and Multiracial MA enrollees each reported experiences with getting appointments and care quickly that were **similar to** the national average for all female MA enrollees. Female AA and NHPI and Hispanic MA enrollees each reported experiences with getting appointments and care quickly that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female White MA enrollees reported experiences with getting appointments and care quickly that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.
- Male AI/AN, Black, and Multiracial MA enrollees each reported experiences with getting appointments and care quickly that were **similar to** the national average for all male MA enrollees. Male AA and NHPI and Hispanic MA enrollees each reported experiences with getting appointments and care quickly that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with getting appointments and care quickly that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on three aspects of customer service,† by race and ethnicity within sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.

NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

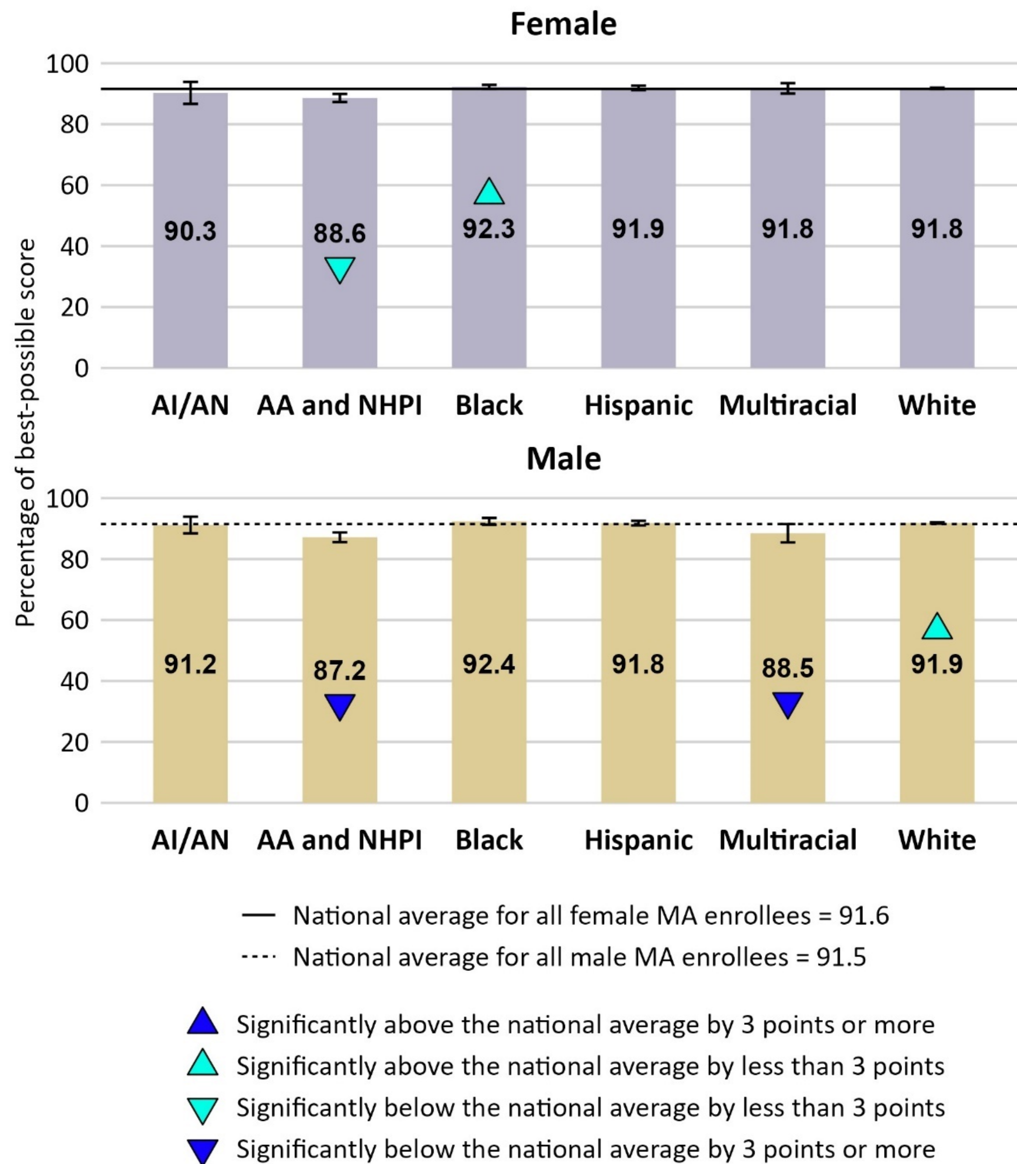
† This includes how often in the last six months health plan customer service staff provided the information or the help that plan members needed, how often plan members were treated with courtesy and respect, and how often forms from the health plan were easy to fill out.

Disparities

- Female AI/AN, Black, Hispanic, and Multiracial MA enrollees each reported experiences with customer service that were **similar to** the national average for all female MA enrollees. Female AA and NHPI MA enrollees reported experiences with customer service that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female White MA enrollees reported experiences with customer service that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.
- Male AI/AN, Black, Hispanic, and Multiracial MA enrollees each reported experiences with customer service that were **similar to** the national average for all male MA enrollees. Male AA and NHPI MA enrollees reported experiences with customer service that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with customer service that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,[†] by race and ethnicity within sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

[†] This includes how often in the last six months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent enough time with patients.

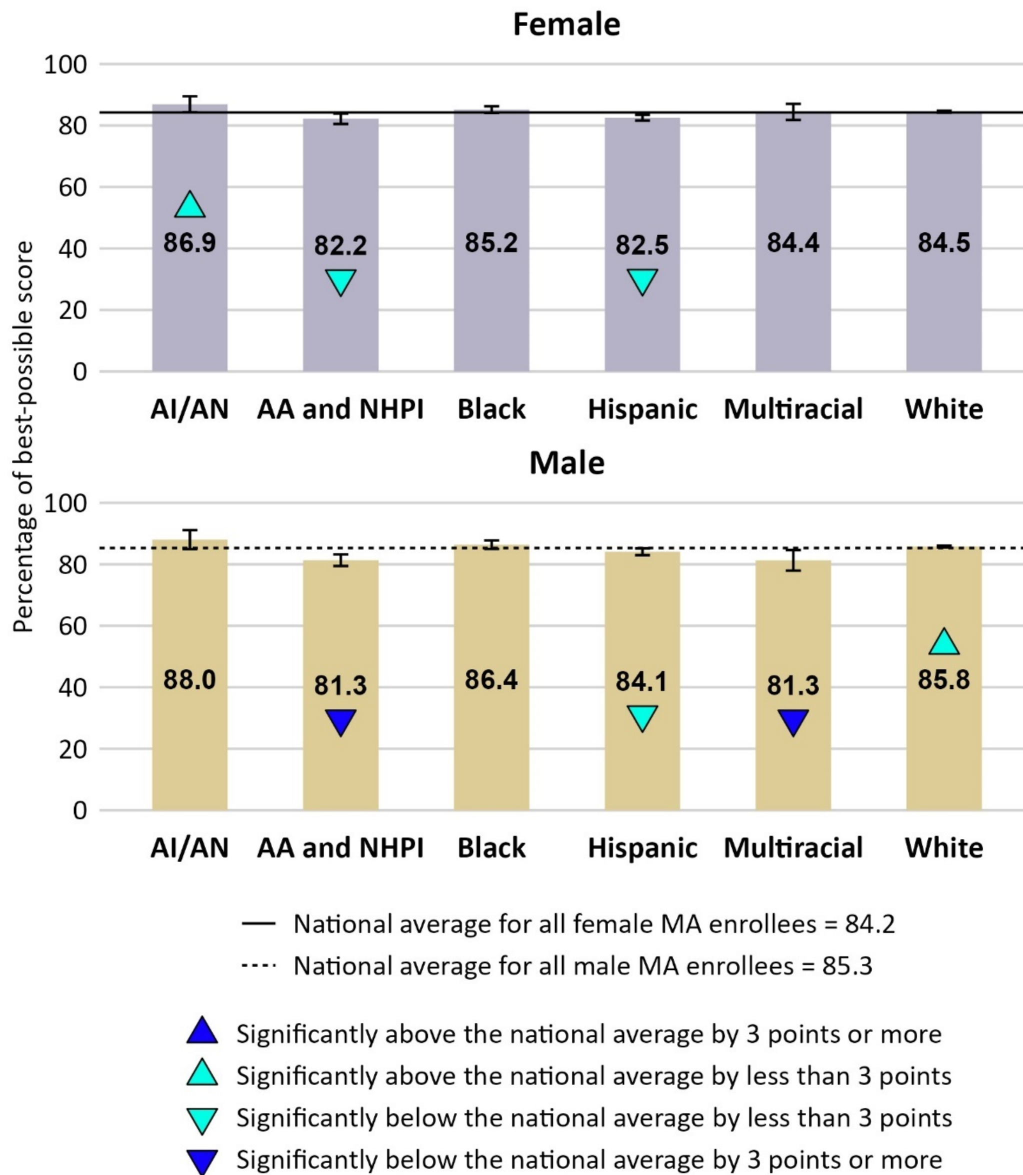
Disparities

- Female AI/AN, Hispanic, Multiracial, and White MA enrollees each reported experiences with doctor communication that were **similar to** the national average for all female MA enrollees. Female AA and NHPI MA enrollees reported experiences with doctor communication that were **below** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.[†] Female Black MA enrollees reported experiences with doctor communication that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.
- Male AI/AN, Black, and Hispanic MA enrollees each reported experiences with doctor communication that were **similar to** the national average for all male MA enrollees. Male AA and NHPI and Multiracial MA enrollees each reported experiences with doctor communication that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with doctor communication that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

[†] Prior to rounding.

Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,[†] by race and ethnicity within sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

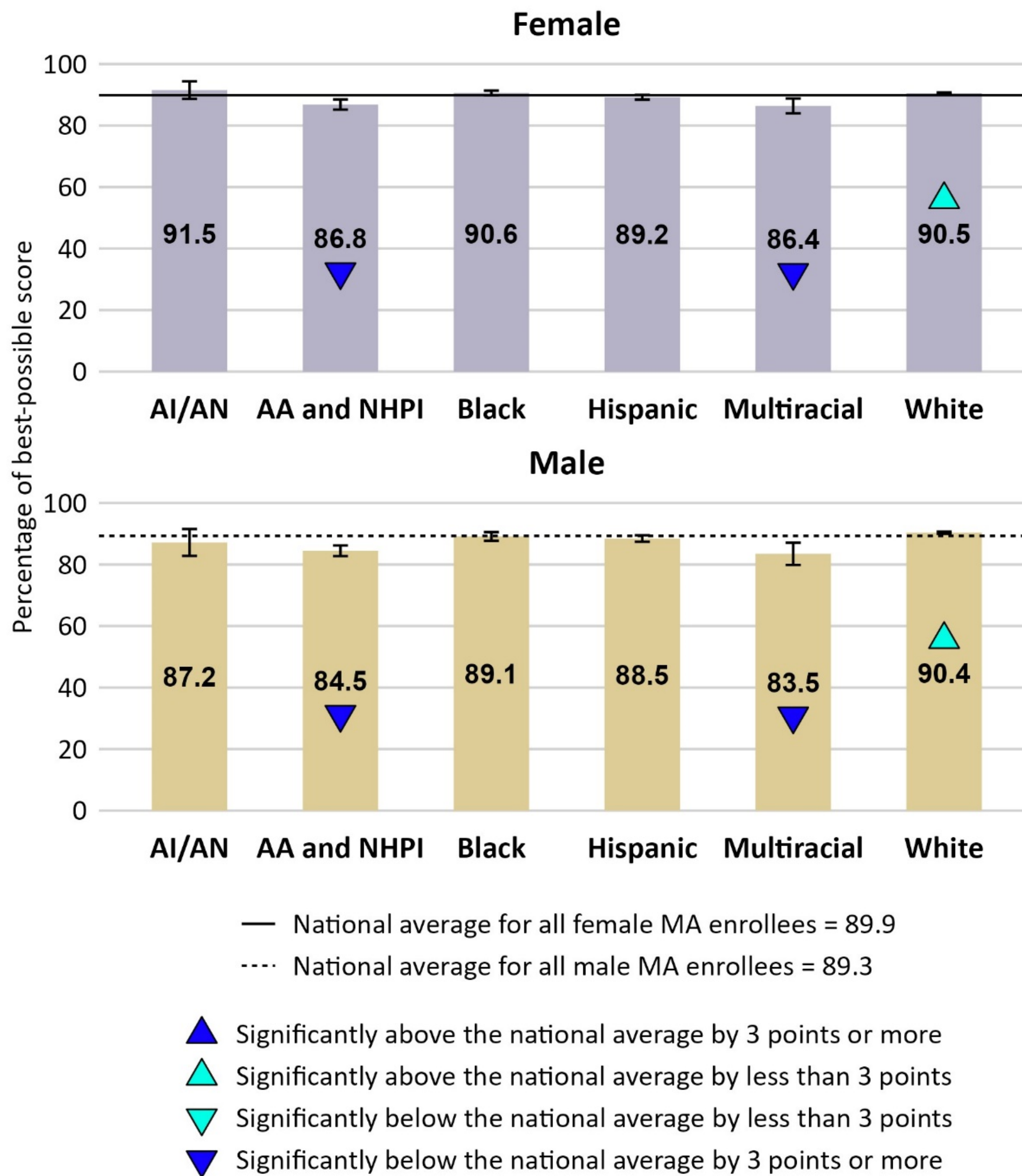
[†] This includes how often in the last six months doctors had medical records and other information about patients' care at patients' scheduled appointments and how quickly patients received their test results.

Disparities

- Female AI/AN MA enrollees reported experiences with care coordination that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale. Female AA and NHPI and Hispanic MA enrollees each reported experiences with care coordination that were **below** the national average for all female MA enrollees by less than 3 points on a 0–100 scale. Female Black, Multiracial, and White MA enrollees each reported experiences with care coordination that were **similar to** the national average for all female MA enrollees.
- Male AI/AN and Black MA enrollees each reported experiences with care coordination that were **similar to** the national average for all male MA enrollees. Male AA and NHPI and Multiracial MA enrollees each reported experiences with care coordination that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male Hispanic MA enrollees reported experiences with care coordination that were **below** the national average for all male MA enrollees by less than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with care coordination that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for people to get the prescription drugs they need using their plan,† by race and ethnicity within sex, 2023



SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

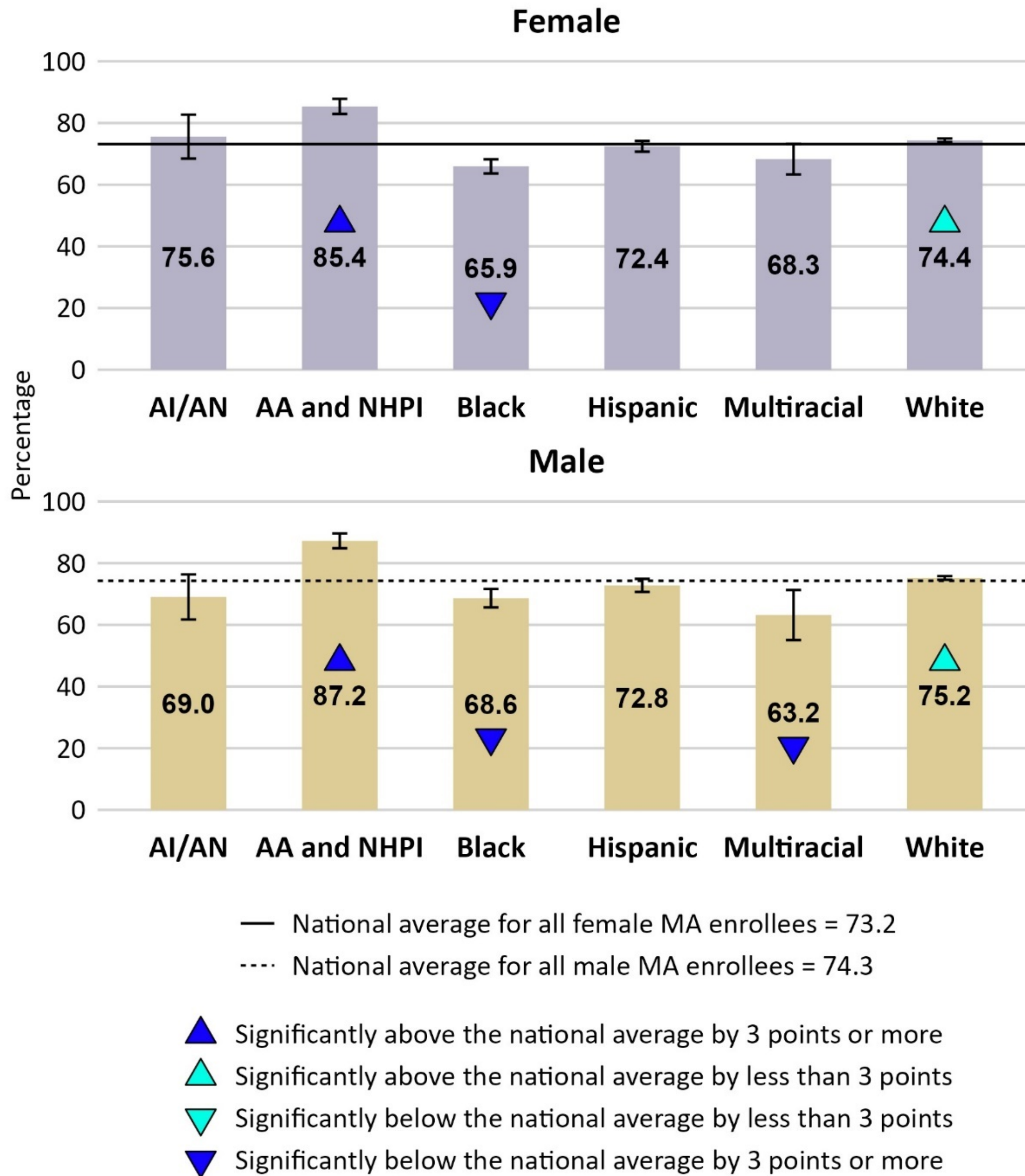
† This includes how often in the last six months it was easy to use the plan to get prescribed medications and how easy it was to fill prescriptions at a pharmacy or by mail.

Disparities

- Female AI/AN, Black, and Hispanic MA enrollees each reported experiences with getting needed prescription drugs that were **similar to** the national average for all female MA enrollees. Female AA and NHPI and Multiracial MA enrollees each reported experiences with getting needed prescription drugs that were **below** the national average for all female MA enrollees by more than 3 points on a 0–100 scale. Female White MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average for all female MA enrollees by less than 3 points on a 0–100 scale.
- Male AI/AN, Black, and Hispanic MA enrollees each reported experiences with getting needed prescription drugs that were **similar to** the national average for all male MA enrollees. Male AA and NHPI and Multiracial MA enrollees each reported experiences with getting needed prescription drugs that were **below** the national average for all male MA enrollees by more than 3 points on a 0–100 scale. Male White MA enrollees reported experiences with getting needed prescription drugs that were **above** the national average for all male MA enrollees by less than 3 points on a 0–100 scale.

Annual Flu Vaccine

Percentage of MA enrollees who got a vaccine (flu shot), by race and ethnicity within sex, 2023



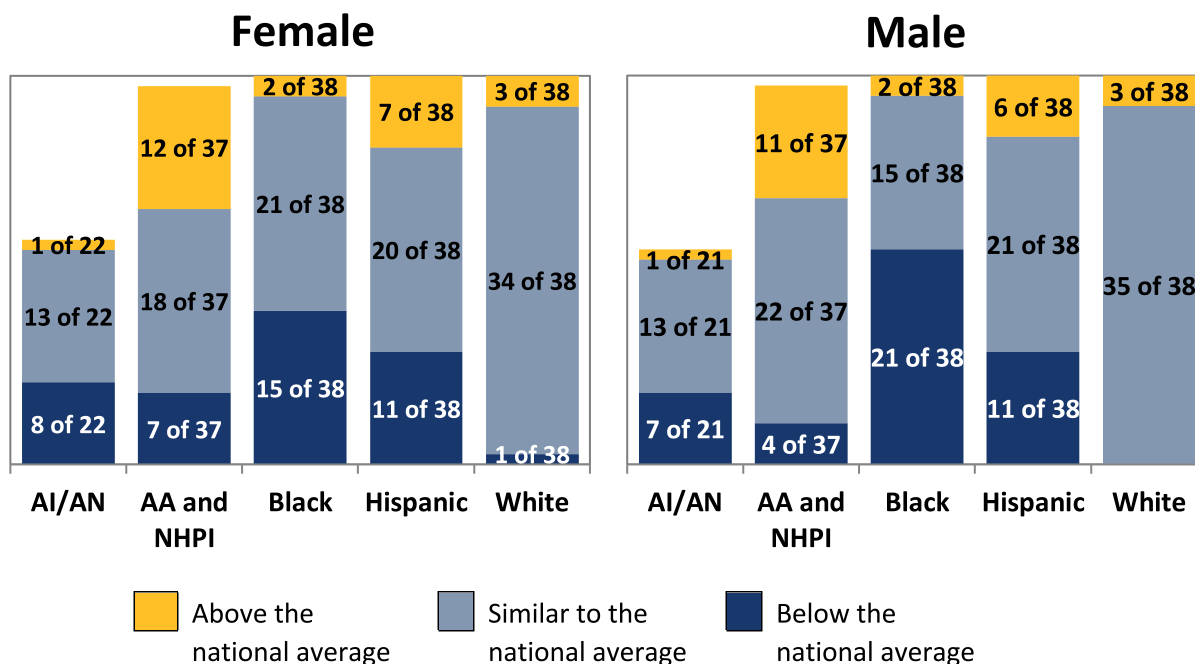
SOURCE: Data are from the 2023 MA CAHPS surveys.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

Disparities

- The percentages of female AI/AN, Hispanic, and Multiracial MA enrollees who received the flu vaccine were each **similar to** the national average for all female MA enrollees. The percentage of female AA and NHPI MA enrollees who received the flu vaccine was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female Black MA enrollees who received the flu vaccine was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of female White MA enrollees who received the flu vaccine was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentages of male AI/AN and Hispanic MA enrollees who received the flu vaccine were each **similar to** the national average for all male MA enrollees. The percentage of male AA and NHPI MA enrollees who received the flu vaccine was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and Multiracial MA enrollees who received the flu vaccine were each **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees who received the flu vaccine was **above** the national average for all male MA enrollees by less than 3 percentage points.

Racial and Ethnic Disparities in Care by Sex: All Clinical Care Measures

Number of clinical care measures for which female or male MA enrollees of selected racial and ethnic groups had results that were above, similar to, or below the national average for all female or male MA enrollees in Reporting Year 2023



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. For reporting clinical care (HEDIS) data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates for AI/AN MA enrollees are less accurate than for other racial and ethnic groups for some measures; for this reason, this report excludes scores for AI/AN MA enrollees when the accuracy of those scores does not meet the standards described on page 271. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Within sex, each racial or ethnic group is compared with the national average for all female and male MA enrollees.

- **Above the national average** = The group received care that was above the national average. The difference is statistically significant ($p < 0.05$) and equal to or larger than 3 points[†] on a 0–100 scale.
- **Similar to the national average** = The group received care that was similar to the national average. The difference is less than 3 points on a 0–100 scale or not statistically significant.
- **Below the national average** = The group received care that was below the national average. The difference is statistically significant and equal to or larger than 3 points[†] on a 0–100 scale.

[†] A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

Female AI/AN MA enrollees had results that were below the national average for all female MA enrollees

- Testing to Confirm COPD
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Medication Adherence for Cardiovascular Disease—Statins
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Kidney Health Evaluation for Patients with Diabetes
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment

Female AI/AN MA enrollees had results that were above the national average for all female MA enrollees

- Initiation of AOD Dependence Treatment

Female AA and NHPI MA enrollees had results that were below the national average for all female MA enrollees

- Testing to Confirm COPD
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Initiation of AOD Dependence Treatment

Female AA and NHPI MA enrollees had results that were above the national average for all female MA enrollees

- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Diabetes Care—Eye Exam
- Diabetes Care—Blood Sugar Controlled
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Kidney Health Evaluation for Patients with Diabetes
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls
- Avoiding Use of High-Risk Medications in Older Adults

Female Black MA enrollees had results that were below the national average for all female MA enrollees

- Controlling High Blood Pressure
- Medication Adherence for Cardiovascular Disease—Statins
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information

Female Black MA enrollees had results that were above the national average for all female MA enrollees

- Initiation of AOD Dependence Treatment
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Female Hispanic MA enrollees had results that were below the national average for all female MA enrollees

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Female Hispanic MA enrollees had results that were above the national average for all female MA enrollees

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Statin Use in Patients with Cardiovascular Disease
- Statin Use in Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Transitions of Care—Medication Reconciliation After Inpatient Discharge

Female White MA enrollees had results that were below the national average for all female MA enrollees

- Kidney Health Evaluation for Patients with Diabetes

Female White MA enrollees had results that were above the national average for all female enrollees

- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Initiation of AOD Dependence Treatment

Male AI/AN MA enrollees had results that were below the national average for all male MA enrollees

- Statin Use in Patients with Cardiovascular Disease
- Medication Adherence for Cardiovascular Disease—Statins
- Statin Use in Patients with Diabetes
- Medication Adherence for Diabetes—Statins
- Kidney Health Evaluation for Patients with Diabetes
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment

Male AI/AN MA enrollees had results that were above the national average for all male MA enrollees

- Initiation of AOD Dependence Treatment

Male AA and NHPI MA enrollees had results that were below the national average for all male MA enrollees

- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Antidepressant Medication Management—Continuation Phase Treatment
- Initiation of AOD Dependence Treatment

Male AA and NHPI MA enrollees had results that were above the national average for all male MA enrollees

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
- Controlling High Blood Pressure
- Statin Use in Patients with Cardiovascular Disease
- Diabetes Care—Eye Exam
- Statin Use in Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls
- Avoiding Use of Opioids at High Dosage

Male Black MA enrollees had results that were below the national average for all male MA enrollees

- Testing to Confirm COPD
- Controlling High Blood Pressure
- Continuous Beta-Blocker Treatment After a Heart Attack
- Medication Adherence for Cardiovascular Disease—Statins
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Diabetes Care—Blood Pressure Controlled
- Diabetes Care—Blood Sugar Controlled
- Medication Adherence for Diabetes—Statins
- Kidney Health Evaluation for Patients with Diabetes
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Transitions of Care—Medication Reconciliation After Inpatient Discharge
- Transitions of Care—Patient Engagement After Inpatient Discharge
- Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Male Black MA enrollees had results that were above the national average for all male MA enrollees

- Initiation of AOD Dependence Treatment
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Male Hispanic MA enrollees had results that were below the national average for all male MA enrollees

- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
- Initiation of Cardiac Rehabilitation
- Engagement of Cardiac Rehabilitation
- Antidepressant Medication Management—Acute Phase Treatment
- Antidepressant Medication Management—Continuation Phase Treatment
- Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)
- Initiation of AOD Dependence Treatment
- Transitions of Care—Notification of Inpatient Admission
- Transitions of Care—Receipt of Discharge Information
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure
- Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

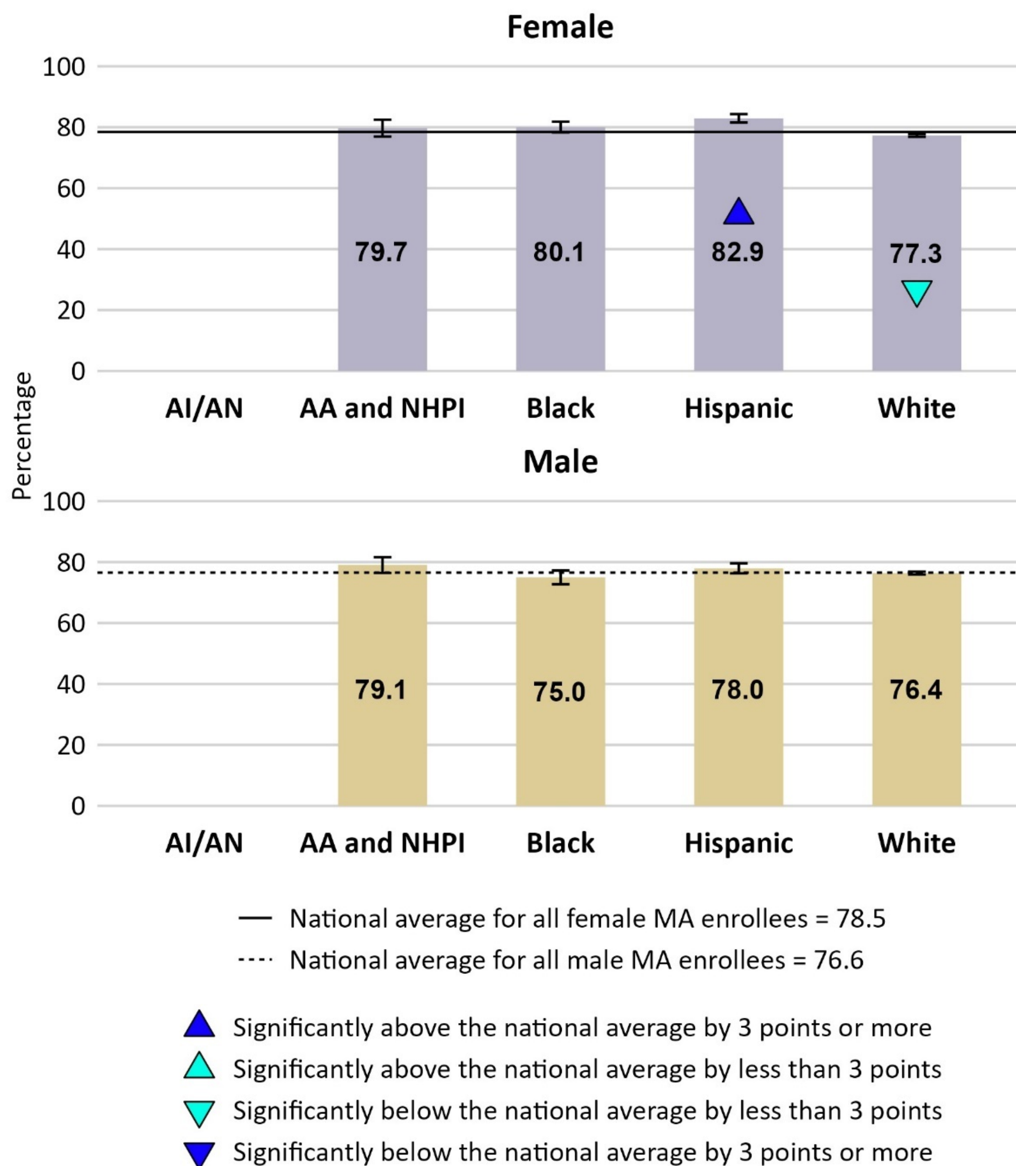
Male Hispanic MA enrollees had results that were above the national average for all male MA enrollees

- Diabetes Care—Eye Exam
- Diabetes Care—Blood Pressure Controlled
- Statin Use in Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)
- Pharmacotherapy for Opioid Use Disorder

Male White MA enrollees had results that were above the national average for all male MA enrollees
• Antidepressant Medication Management—Continuation Phase Treatment • Adherence to Antipsychotic Medications for Individuals with Schizophrenia • Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)

Colorectal Cancer Screening

Percentage of MA enrollees aged 50 to 75 years who had appropriate screening for colorectal cancer, by race and ethnicity within sex, Reporting Year 2023



— National average for all female MA enrollees = 78.5

---- National average for all male MA enrollees = 76.6

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentages of eligible[†] female AA and NHPI and Black MA enrollees who were appropriately screened for colorectal cancer were each **similar to** the national average for all eligible female MA enrollees. The percentage of eligible female Hispanic MA enrollees who were appropriately screened for colorectal cancer was **above** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who were appropriately screened for colorectal cancer was **below** the national average for all eligible female MA enrollees by less than 3 percentage points.[‡]
- The percentages of eligible male AA and NHPI, Black, Hispanic, and White MA enrollees who were appropriately screened for colorectal cancer were each **similar to** the national average for all eligible male MA enrollees.

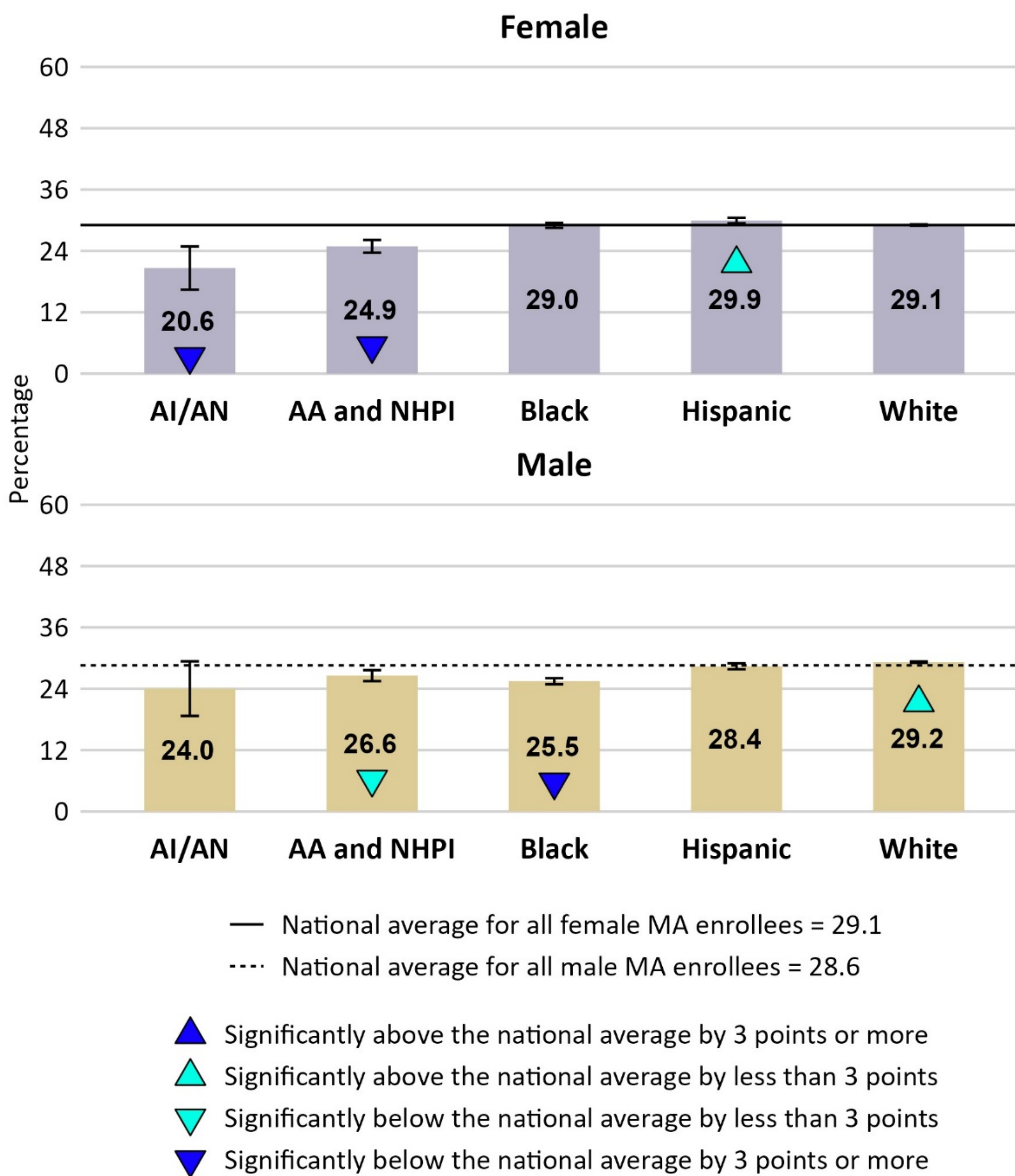
[†] In discussing clinical care measures that have criteria for being included in the denominator of the measure, *eligible* is sometimes used to refer to people who meet the inclusion criteria (which are specified in the chart subtitle).

[‡] Unlike on pp. 189–194, we describe all statistically significant differences on individual measures as either above or below the national average and note whether those differences are more or less than 3 points.

Clinical Care: Respiratory Conditions

Testing to Confirm COPD

Percentage of MA enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by race and ethnicity within sex, Reporting Year 2023



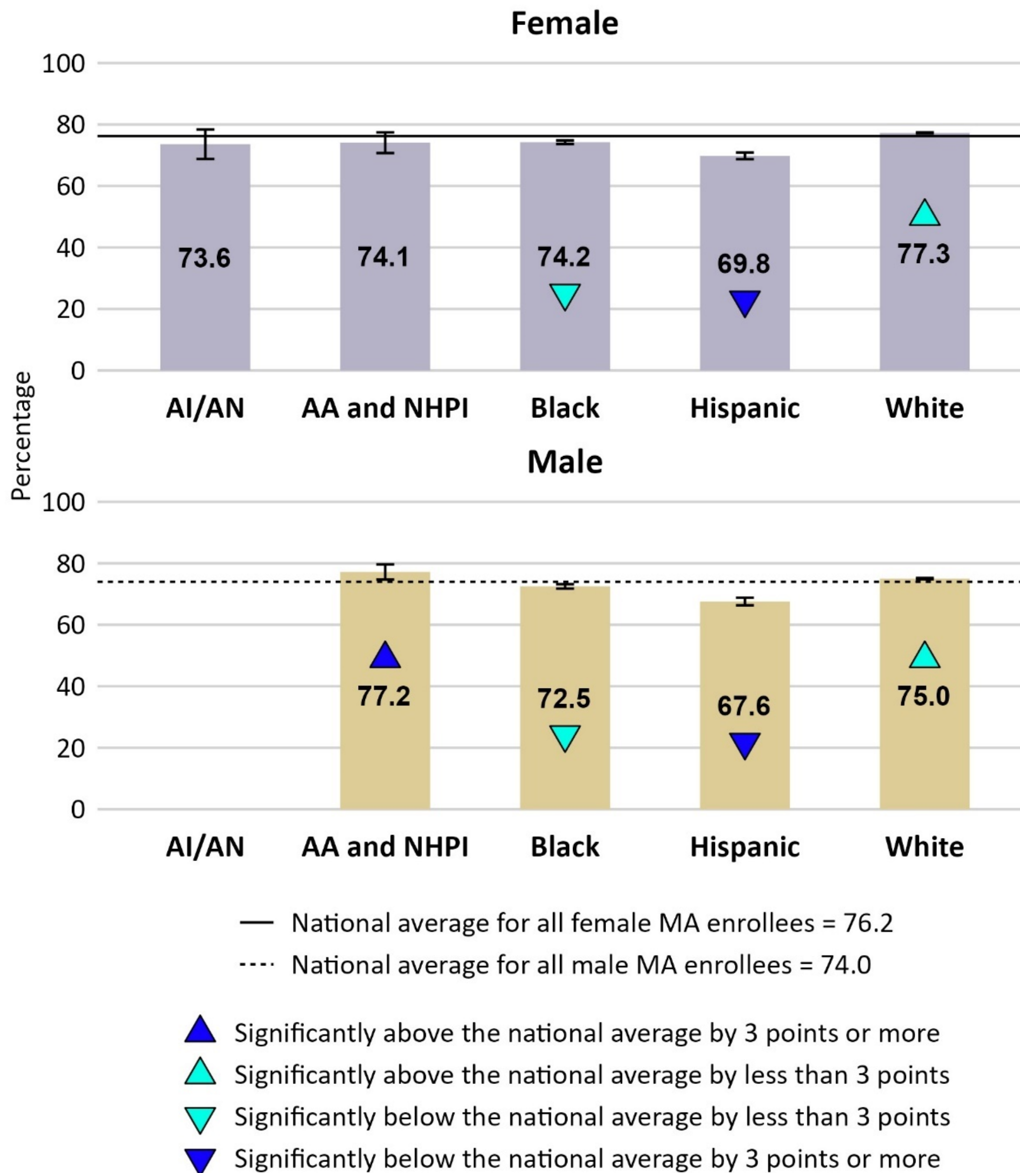
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

Disparities

- The percentages of eligible female AI/AN and AA and NHPI MA enrollees who received a spirometry test to confirm a diagnosis of COPD were each **below** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentages of eligible female Black and White MA enrollees who received a spirometry test to confirm a diagnosis of COPD were each **similar to** the national average for all eligible female MA enrollees. The percentage of eligible female Hispanic MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentages of eligible male AI/AN and Hispanic MA enrollees who received a spirometry test to confirm a diagnosis of COPD were each **similar to** the national average for all eligible male MA enrollees. The percentage of eligible male AA and NHPI MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible male MA enrollees by less than 3 percentage points. The percentage of eligible male Black MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **below** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male White MA enrollees who received a spirometry test to confirm a diagnosis of COPD was **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a systemic corticosteroid within 14 days of the event, by race and ethnicity within sex, Reporting Year 2023



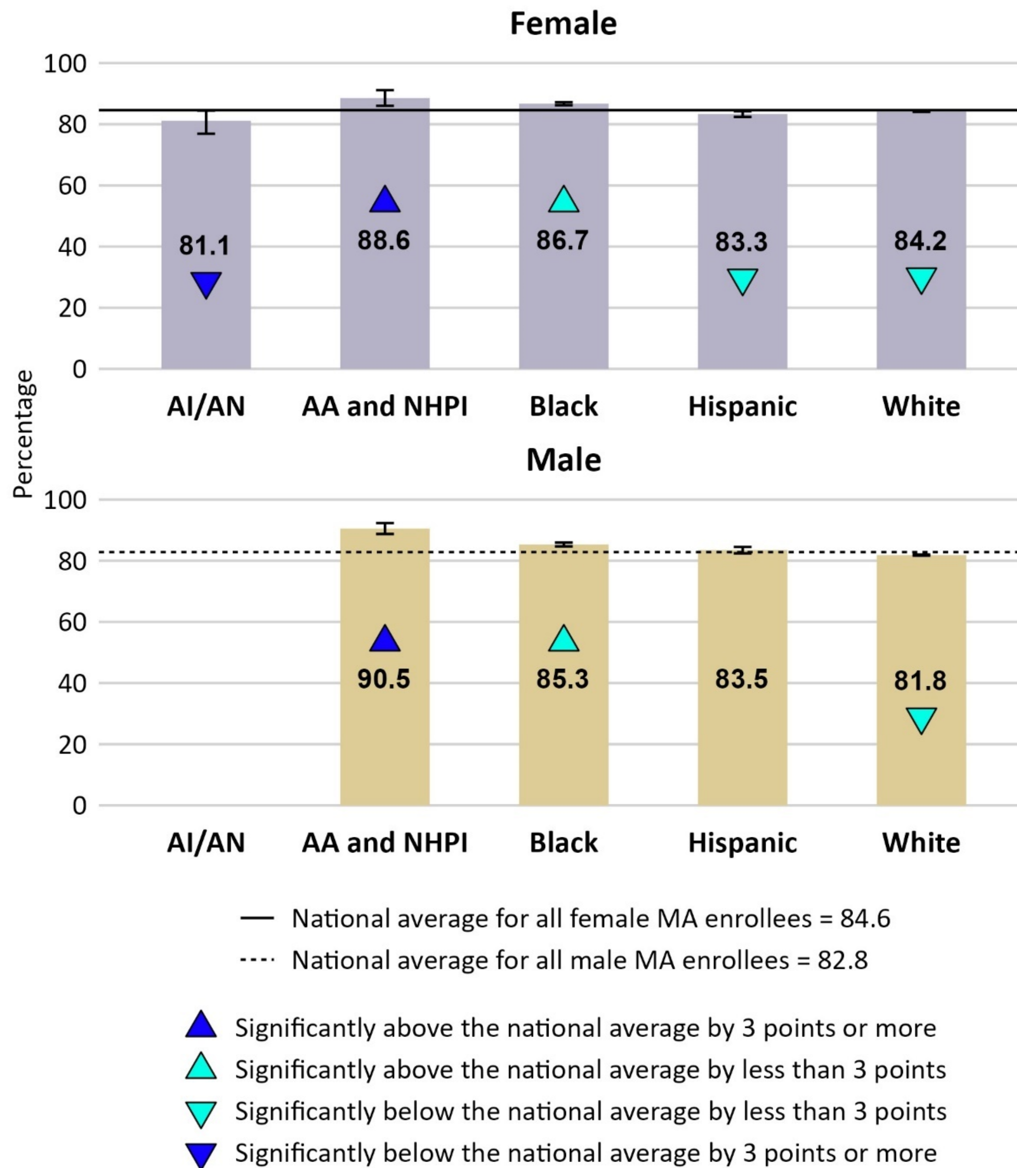
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for male AI/AN MA enrollees is not accurate enough to report.

Disparities

- The percentages of eligible female AI/AN and AA and NHPI MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation were each **similar to** the national average for all eligible female MA enrollees. The percentage of eligible female Black MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible female MA enrollees by less than 3 percentage points. The percentage of eligible female Hispanic MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentage of eligible male AA and NHPI MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male Black MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible male MA enrollees by less than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **below** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male White MA enrollees who were dispensed a systemic corticosteroid within 14 days of a COPD exacerbation was **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or ED encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for male AI/AN MA enrollees is not accurate enough to report.

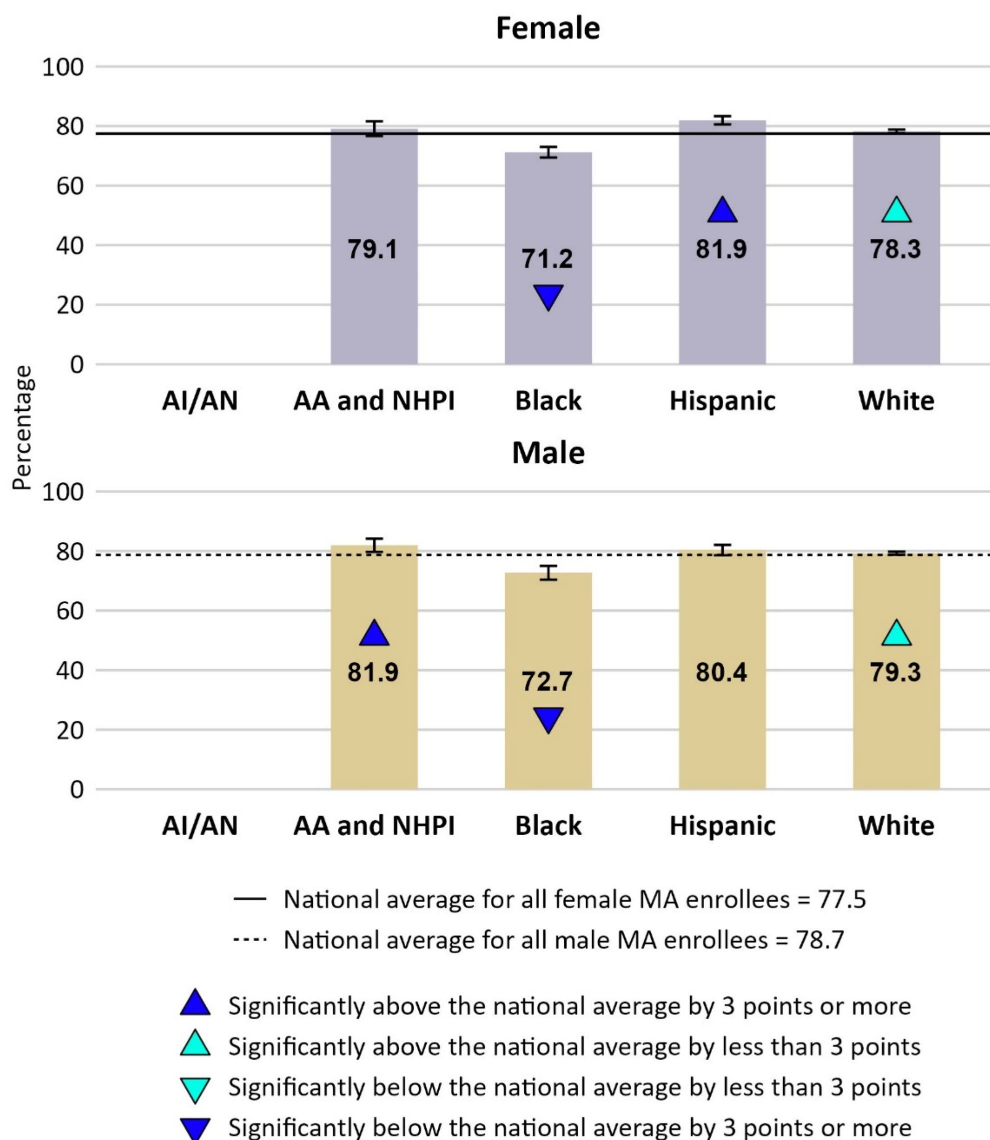
Disparities

- The percentage of eligible female AI/AN MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of eligible female AA and NHPI MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of eligible female Black MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible female MA enrollees by less than 3 percentage points. The percentages of eligible female Hispanic and White MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation were each **below** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentage of eligible male AA and NHPI MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male Black MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **above** the national average for all eligible male MA enrollees by less than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **similar to** the national average for all eligible male MA enrollees. The percentage of eligible male White MA enrollees who were dispensed a bronchodilator within 30 days of a COPD exacerbation was **below** the national average for all eligible male MA enrollees by less than 3 percentage points.

Clinical Care: Cardiovascular Conditions

Controlling High Blood Pressure

Percentage of MA enrollees aged 18 to 85 years with a diagnosis of hypertension whose blood pressure was adequately controlled† during the past year, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

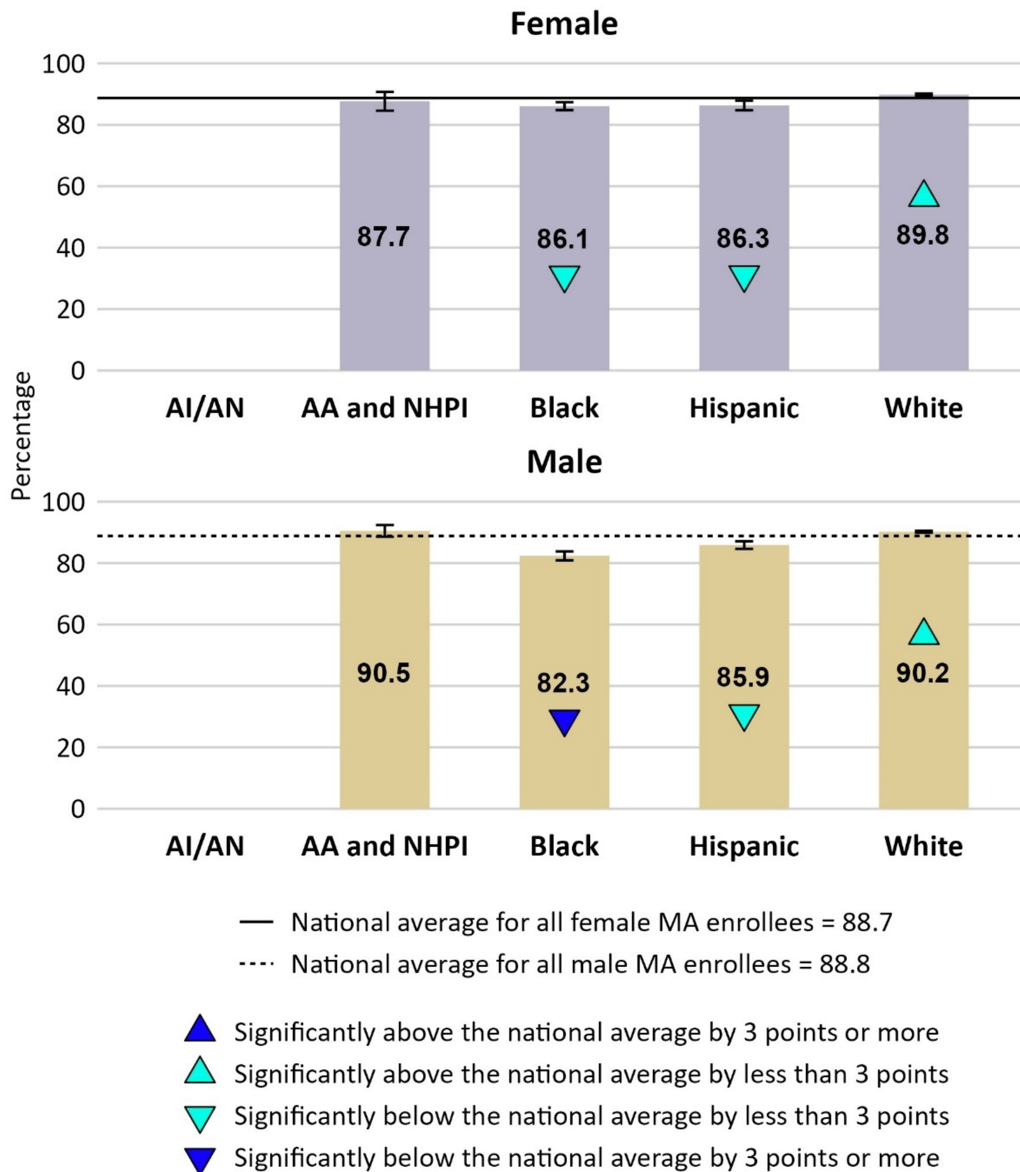
† Less than 140/90 for patients 18 to 59 years of age and for patients 60 to 85 years of age with a diagnosis of diabetes, or less than 150/90 for patients 60 to 85 years of age without a diagnosis of diabetes.

Disparities

- The percentage of eligible female AA and NHPI MA enrollees who had their blood pressure adequately controlled was **similar to** the national average for all female MA enrollees. The percentage of eligible female Black MA enrollees who had their blood pressure adequately controlled was **below** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female Hispanic MA enrollees who had their blood pressure adequately controlled was **above** the national average for all female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who had their blood pressure adequately controlled was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of eligible male AA and NHPI MA enrollees who had their blood pressure adequately controlled was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male Black MA enrollees who had their blood pressure adequately controlled was **below** the national average for all male MA enrollees by more than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who had their blood pressure adequately controlled was **similar to** the national average for all male MA enrollees. The percentage of eligible male White MA enrollees who had their blood pressure adequately controlled was **above** the national average for all male MA enrollees by less than 3 percentage points.

Continuous Beta-Blocker Treatment After a Heart Attack

Percentage of MA enrollees aged 18 years and older who were hospitalized and discharged with a diagnosis of acute myocardial infarction (AMI) who received continuous beta-blocker treatment for six months after discharge, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

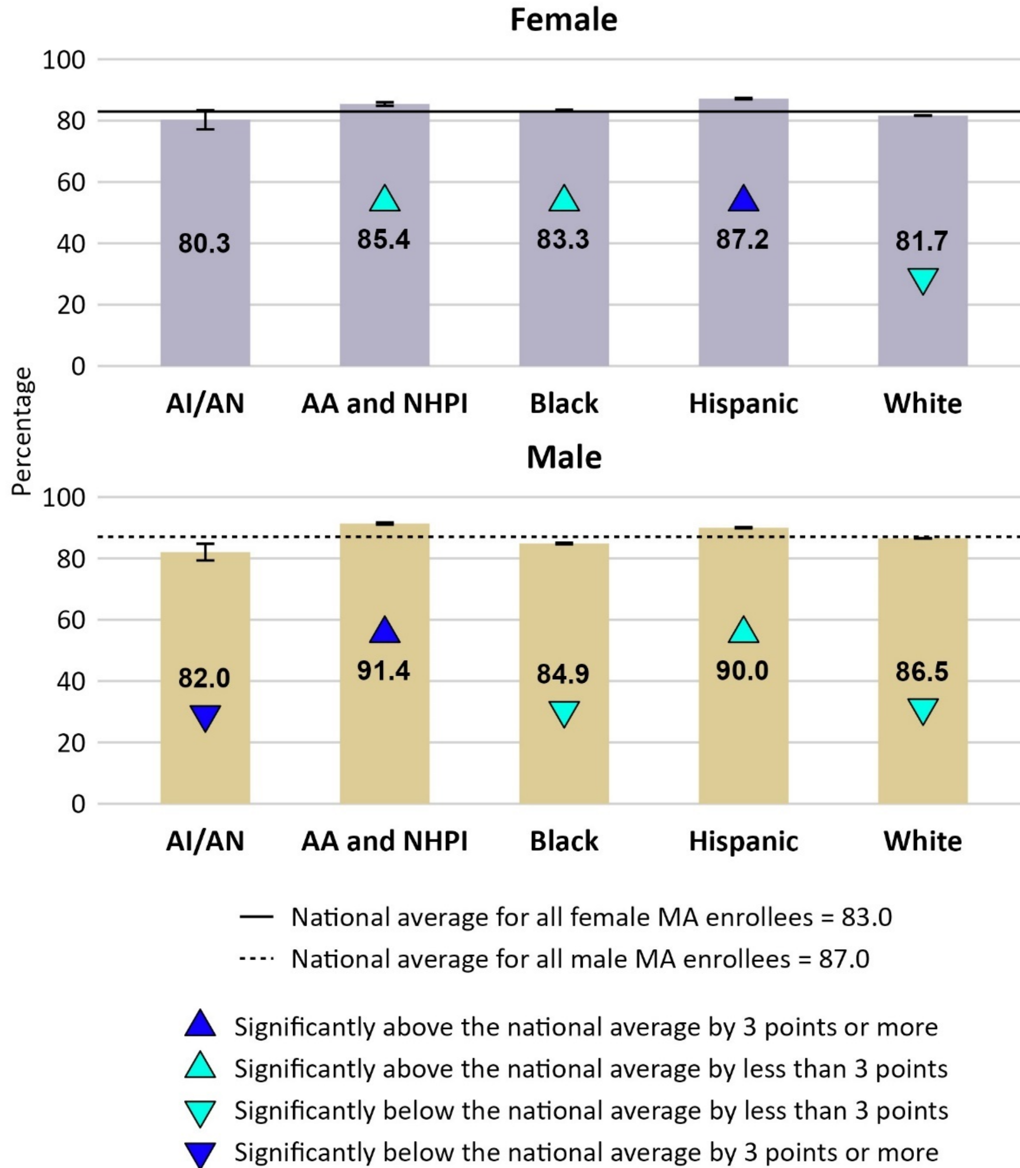
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentage of eligible female AA and NHPI MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all eligible female MA enrollees. The percentages of eligible female Black and Hispanic MA enrollees who received continuous beta-blocker treatment were each **below** the national average for all eligible female MA enrollees by less than 3 percentage points. The percentage of eligible female White MA enrollees who received continuous beta-blocker treatment was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentage of eligible male AA and NHPI MA enrollees who received continuous beta-blocker treatment was **similar to** the national average for all eligible male MA enrollees. The percentage of eligible male Black MA enrollees who received continuous beta-blocker treatment was **below** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male Hispanic MA enrollees who received continuous beta-blocker treatment was **below** the national average for all eligible male MA enrollees by less than 3 percentage points. The percentage of eligible male White MA enrollees who received continuous beta blocker treatment was **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

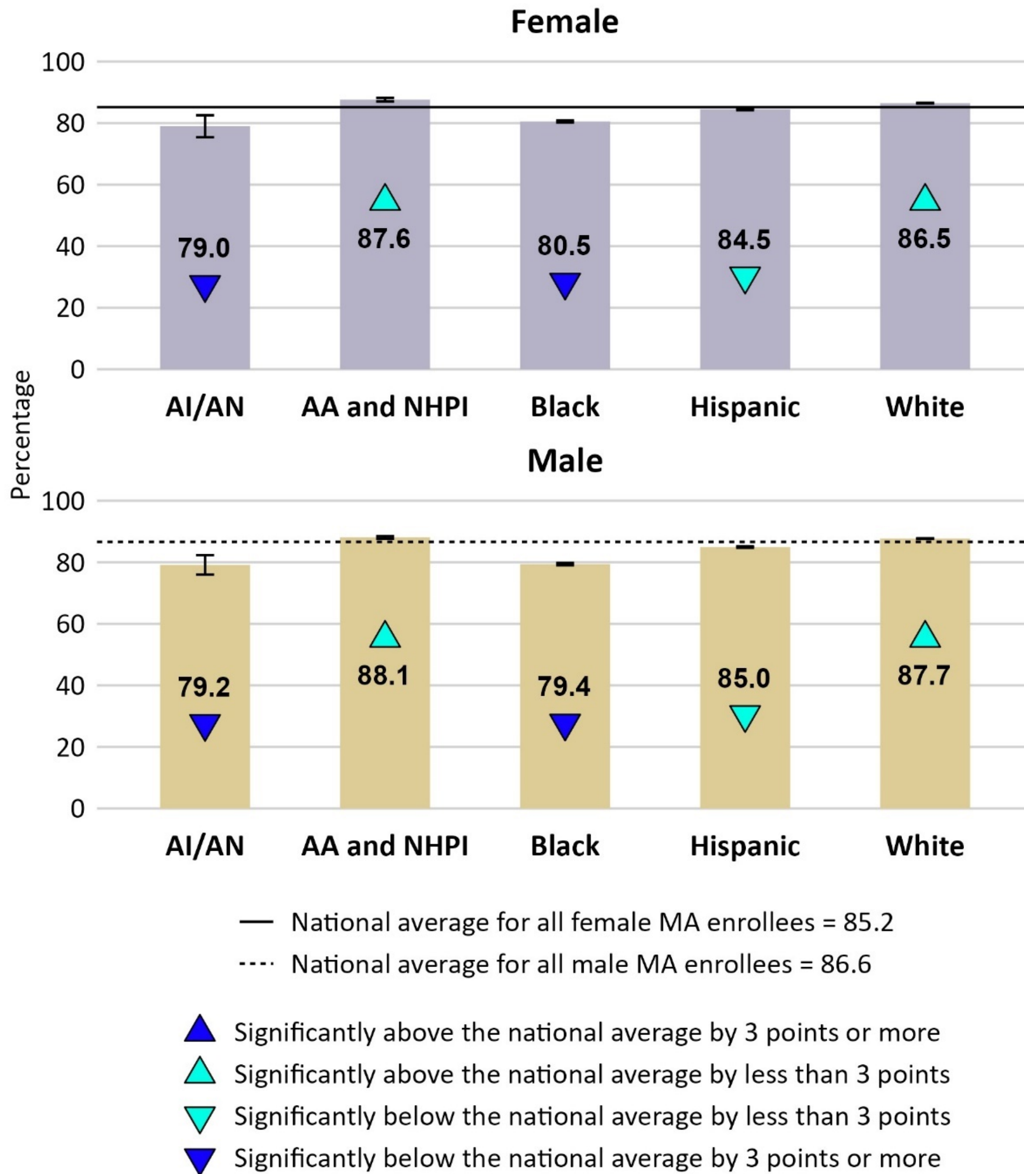
Disparities

- The percentage of female AI/AN MA enrollees with clinical ASCVD who received statin therapy was **similar to** the national average for all female MA enrollees with clinical ASCVD. The percentages of female AA and NHPI and Black MA enrollees with clinical ASCVD who received statin therapy were each **above** the national average for all female MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of female Hispanic MA enrollees with clinical ASCVD who received statin therapy was **above** the national average for all female MA enrollees with clinical ASCVD by more than 3 percentage points. The percentage of female White MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all female MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees with clinical ASCVD who received statin therapy was **below** the national average for all male MA enrollees with clinical ASCVD by more than 3 percentage points. The percentage of male AA and NHPI MA enrollees with clinical ASCVD who received statin therapy was **above** the national average for all male MA enrollees with clinical ASCVD by more than 3 percentage points. The percentages of male Black and White MA enrollees with clinical ASCVD who received statin therapy were each **below** the national average for all male MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of male Hispanic MA enrollees with clinical ASCVD who received statin therapy was **above** the national average for all male MA enrollees with clinical ASCVD by less than 3 percentage points.[†]

[†] Prior to rounding.

Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years with clinical ASCVD who were dispensed a statin medication and remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within sex, Reporting Year 2023



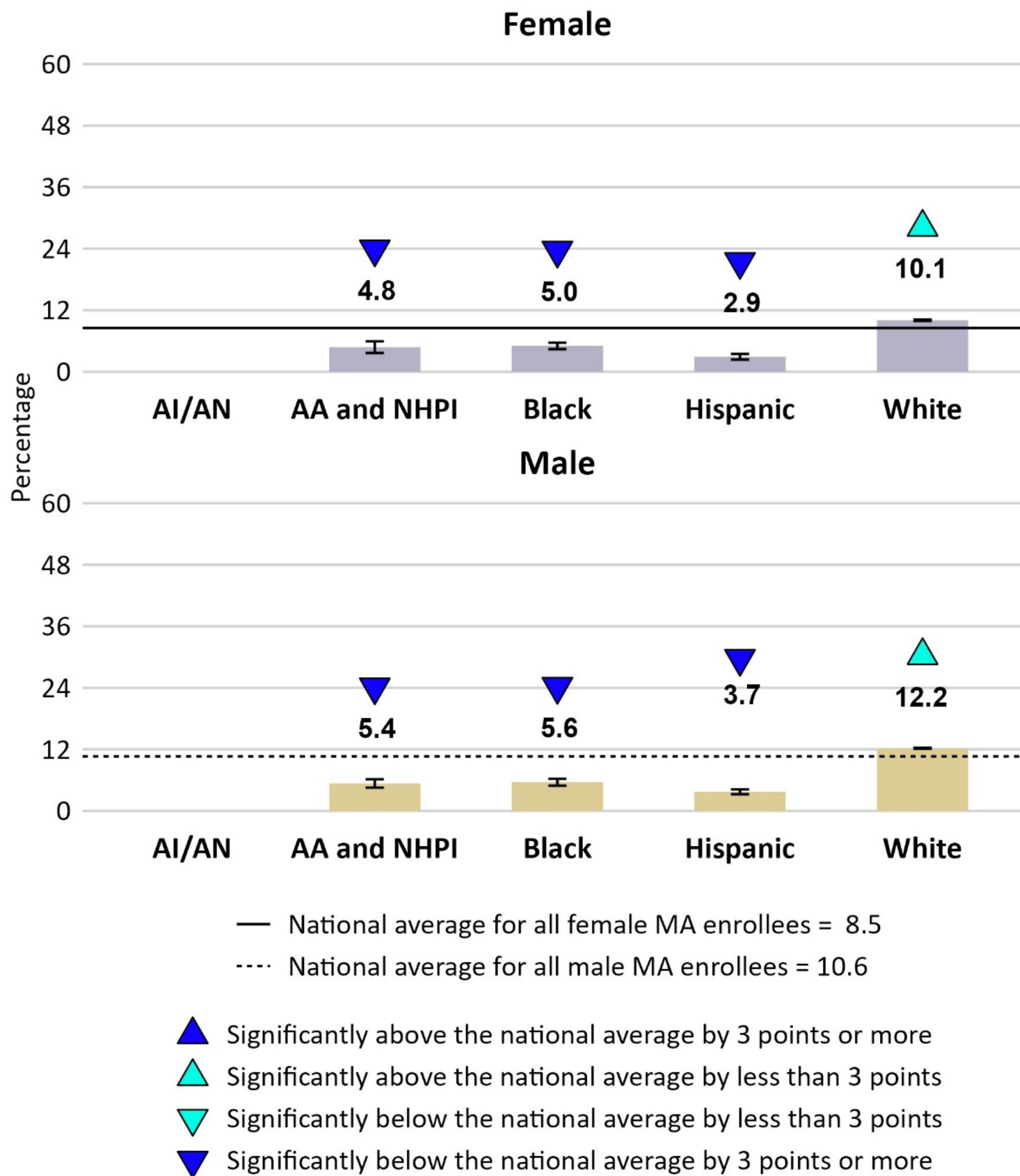
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of female AI/AN and Black MA enrollees with clinical ASCVD who had proper statin medication adherence were each **below** the national average for all female MA enrollees with clinical ASCVD by more than 3 percentage points. The percentages of female AA and NHPI and White MA enrollees with clinical ASCVD who had proper statin medication adherence were each **above** the national average for all female MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of female Hispanic MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all female MA enrollees with clinical ASCVD by less than 3 percentage points.
- The percentages of male AI/AN and Black MA enrollees with clinical ASCVD who had proper statin medication adherence were each **below** the national average for all male MA enrollees with clinical ASCVD by more than 3 percentage points. The percentages of male AA and NHPI and White MA enrollees with clinical ASCVD who had proper statin medication adherence were each **above** the national average for all male MA enrollees with clinical ASCVD by less than 3 percentage points. The percentage of male Hispanic MA enrollees with clinical ASCVD who had proper statin medication adherence was **below** the national average for all male MA enrollees with clinical ASCVD by less than 3 percentage points.

Initiation of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older† who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

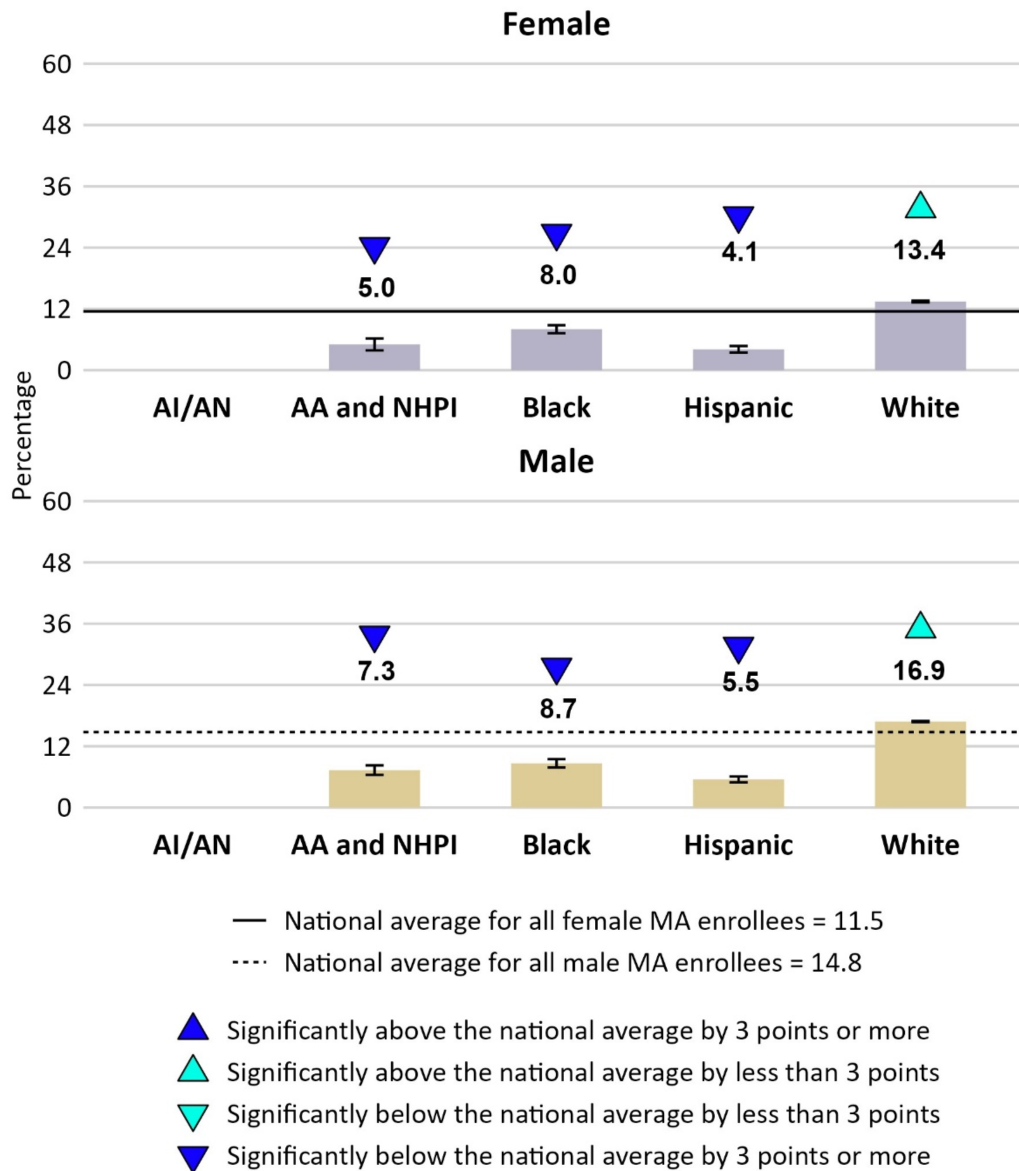
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentages of female AA and NHPI, Black, and Hispanic MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event were each **below** the national average for all female MA enrollees who had a cardiac event by more than 3 percentage points. The percentage of female White MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all female MA enrollees who had a cardiac event by less than 3 percentage points.
- The percentages of male AA and NHPI, Black, and Hispanic MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event were each **below** the national average for all male MA enrollees who had a cardiac event by more than 3 percentage points. The percentage of male White MA enrollees who had a cardiac event who attended two or more sessions of cardiac rehabilitation within 30 days of a cardiac event was **above** the national average for all male MA enrollees who had a cardiac event by less than 3 percentage points.

Engagement of Cardiac Rehabilitation

Percentage of MA enrollees aged 65 years and older† who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

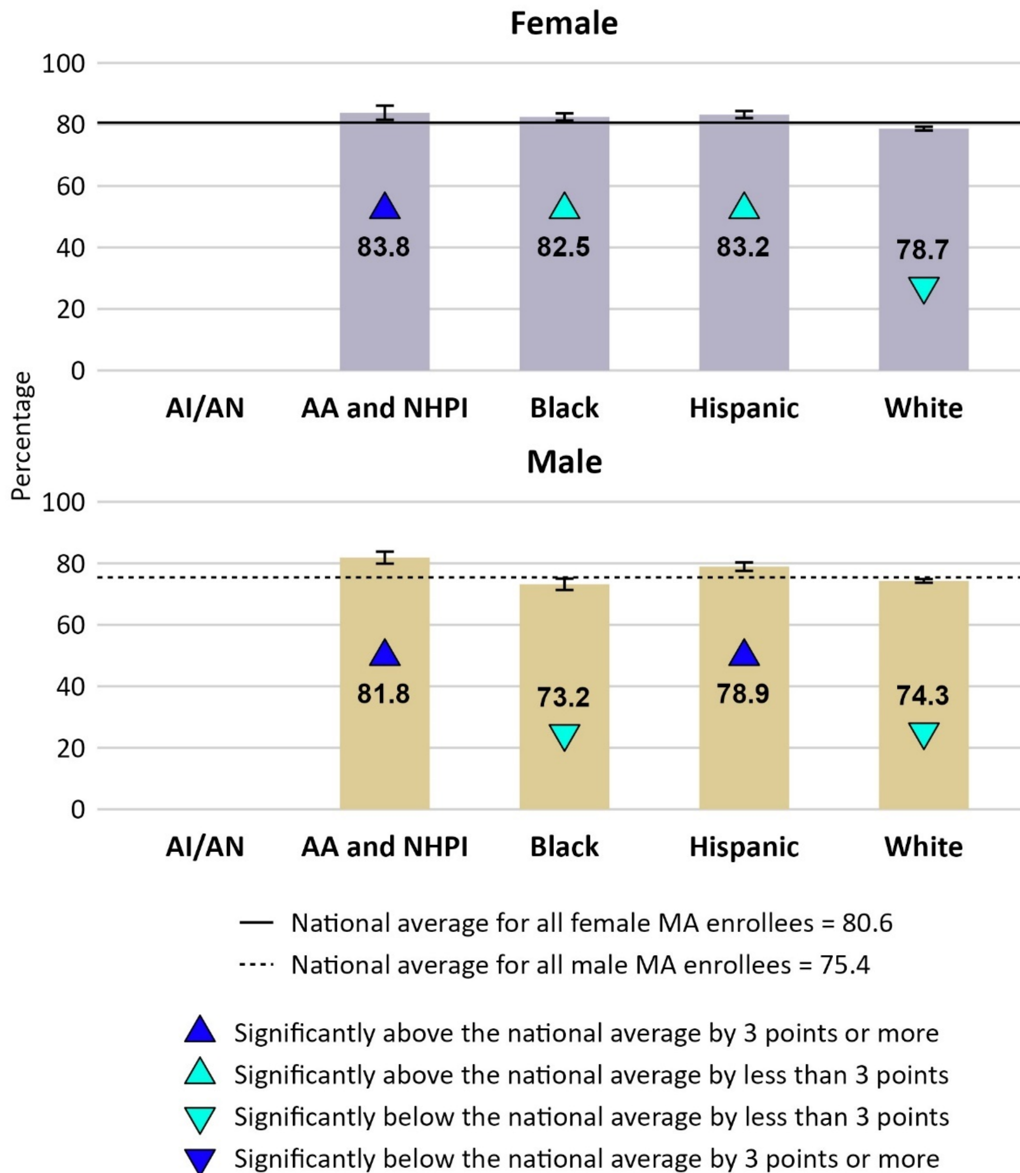
Disparities

- The percentages of female AA and NHPI, Black, and Hispanic MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event were each **below** the national average for all female MA enrollees who had a cardiac event by more than 3 percentage points. The percentage of female White MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all female MA enrollees who had a cardiac event by less than 3 percentage points.
- The percentages of male AA and NHPI, Black, and Hispanic MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event were each **below** the national average for all male MA enrollees who had a cardiac event by more than 3 percentage points. The percentage of male White MA enrollees who attended 12 or more sessions of cardiac rehabilitation within 90 days of a cardiac event was **above** the national average for all male MA enrollees who had a cardiac event by less than 3 percentage points.

Clinical Care: Diabetes

Diabetes Care—Eye Exam

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by race and ethnicity within sex, Reporting Year 2023



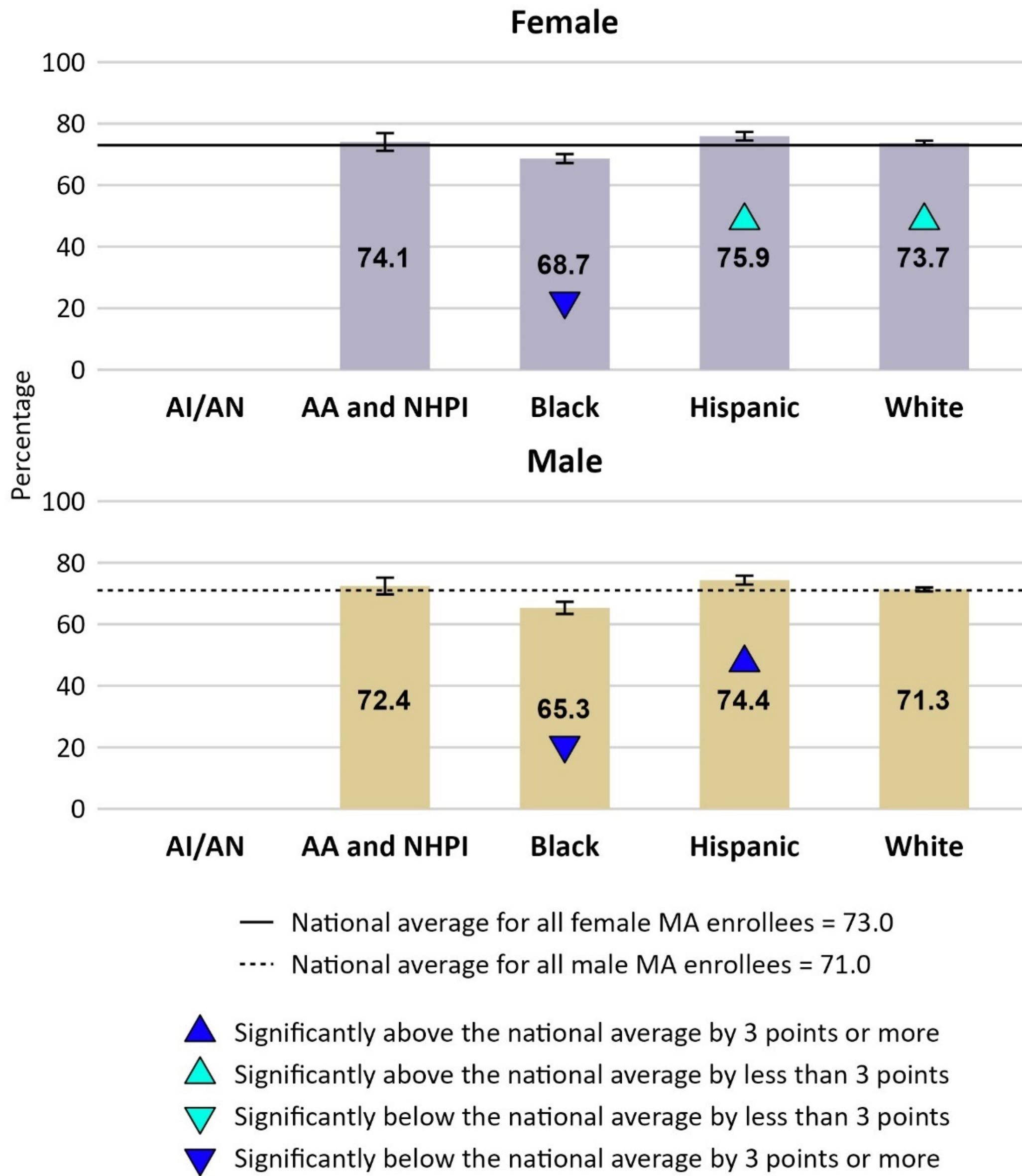
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentage of female AA and NHPI MA enrollees with diabetes who had an eye exam in the past year was **above** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentages of female Black and Hispanic MA enrollees with diabetes who had an eye exam in the past year were each **above** the national average for all female MA enrollees with diabetes by less than 3 percentage points. The percentage of female White MA enrollees with diabetes who had an eye exam in the past year was **below** the national average for all female MA enrollees with diabetes by less than 3 percentage points.
- The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who had an eye exam in the past year were each **above** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentages of male Black and White MA enrollees with diabetes who had an eye exam in the past year were each **below** the national average for all male MA enrollees with diabetes by less than 3 percentage points.

Diabetes Care—Blood Pressure Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by race and ethnicity within sex, Reporting Year 2023



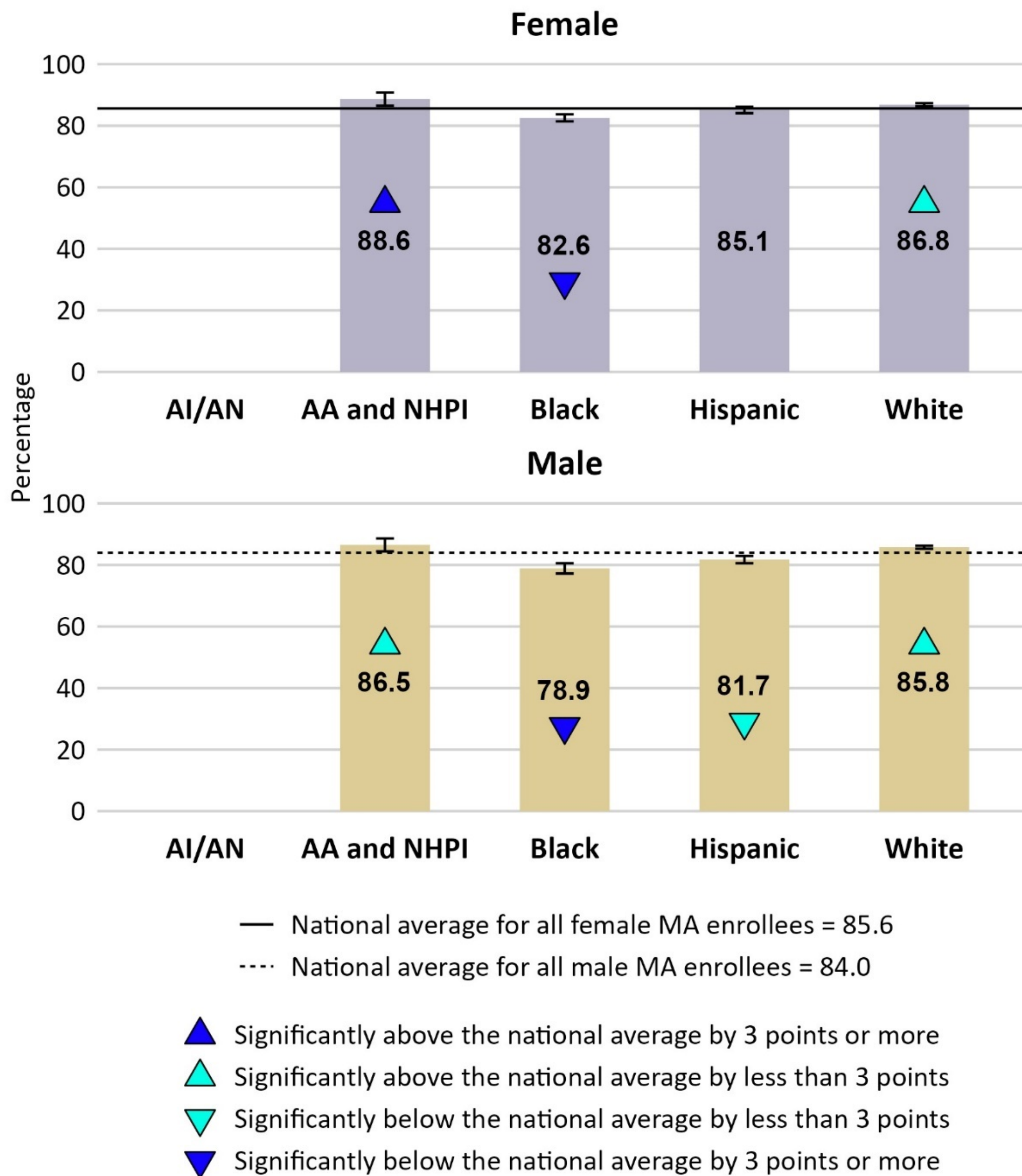
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

Disparities

- The percentage of female AA and NHPI MA enrollees with diabetes who had their blood pressure under control was **similar to** the national average for all female MA enrollees with diabetes. The percentage of female Black MA enrollees with diabetes who had their blood pressure under control was **below** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentages of female Hispanic and White MA enrollees with diabetes who had their blood pressure under control were each **above** the national average for all female MA enrollees with diabetes by less than 3 percentage points.
- The percentages of male AA and NHPI and White MA enrollees with diabetes who had their blood pressure under control were each **similar to** the national average for all male MA enrollees with diabetes. The percentage of male Black MA enrollees with diabetes who had their blood pressure under control was **below** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentage of male Hispanic MA enrollees with diabetes who had their blood pressure under control was **above** the national average for all male MA enrollees with diabetes by more than 3 percentage points.

Diabetes Care—Blood Sugar Controlled

Percentage of MA enrollees aged 18 to 75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

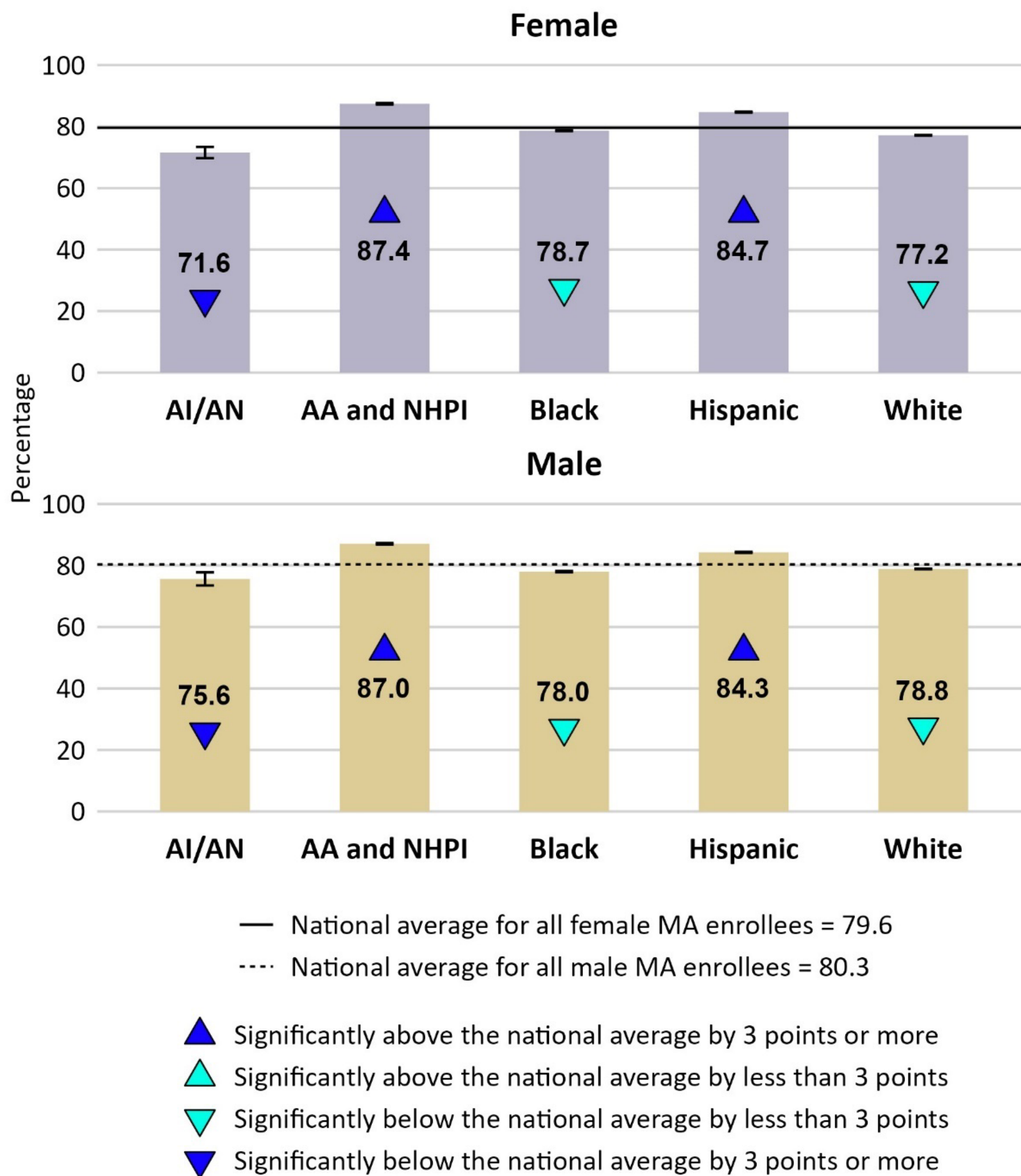
Disparities

- The percentage of female AA and NHPI MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all female MA enrollees with diabetes by more than 3 percentage points.† The percentage of female Black MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all female MA enrollees with diabetes by more than 3 percentage points.† The percentage of female Hispanic MA enrollees with diabetes who had their blood sugar level under control was **similar to** the national average for all female MA enrollees with diabetes. The percentage of female White MA enrollees with diabetes who had their blood sugar level under control was **above** the national average for all female MA enrollees with diabetes by less than 3 percentage points.
- The percentages of male AA and NHPI and White MA enrollees with diabetes who had their blood sugar level under control were each **above** the national average for all male MA enrollees with diabetes by less than 3 percentage points. The percentage of male Black MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentage of male Hispanic MA enrollees with diabetes who had their blood sugar level under control was **below** the national average for all male MA enrollees with diabetes by less than 3 percentage points.

† Prior to rounding.

Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who received statin therapy, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

---

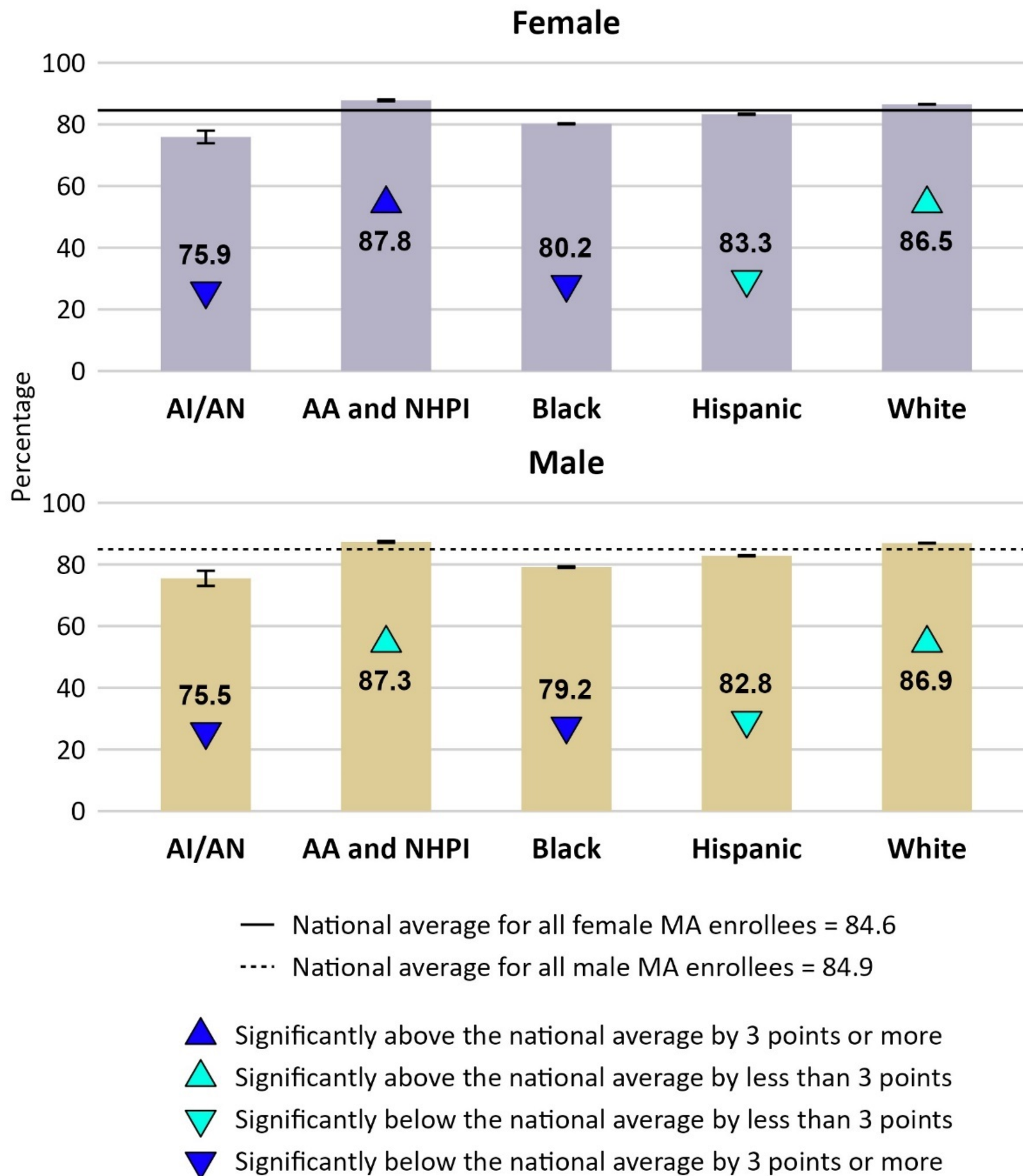
† Excludes those who also have clinical ASCVD.

Disparities

- The percentage of female AI/AN MA enrollees with diabetes who received statin therapy was **below** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees with diabetes who received statin therapy were each **above** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentages of female Black and White MA enrollees with diabetes who received statin therapy were each **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees with diabetes who received statin therapy was **below** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who received statin therapy were each **above** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentages of male Black and White MA enrollees with diabetes who received statin therapy were each **below** the national average for all male MA enrollees with diabetes by less than 3 percentage points.

Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)[†] who were dispensed a statin medication and remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

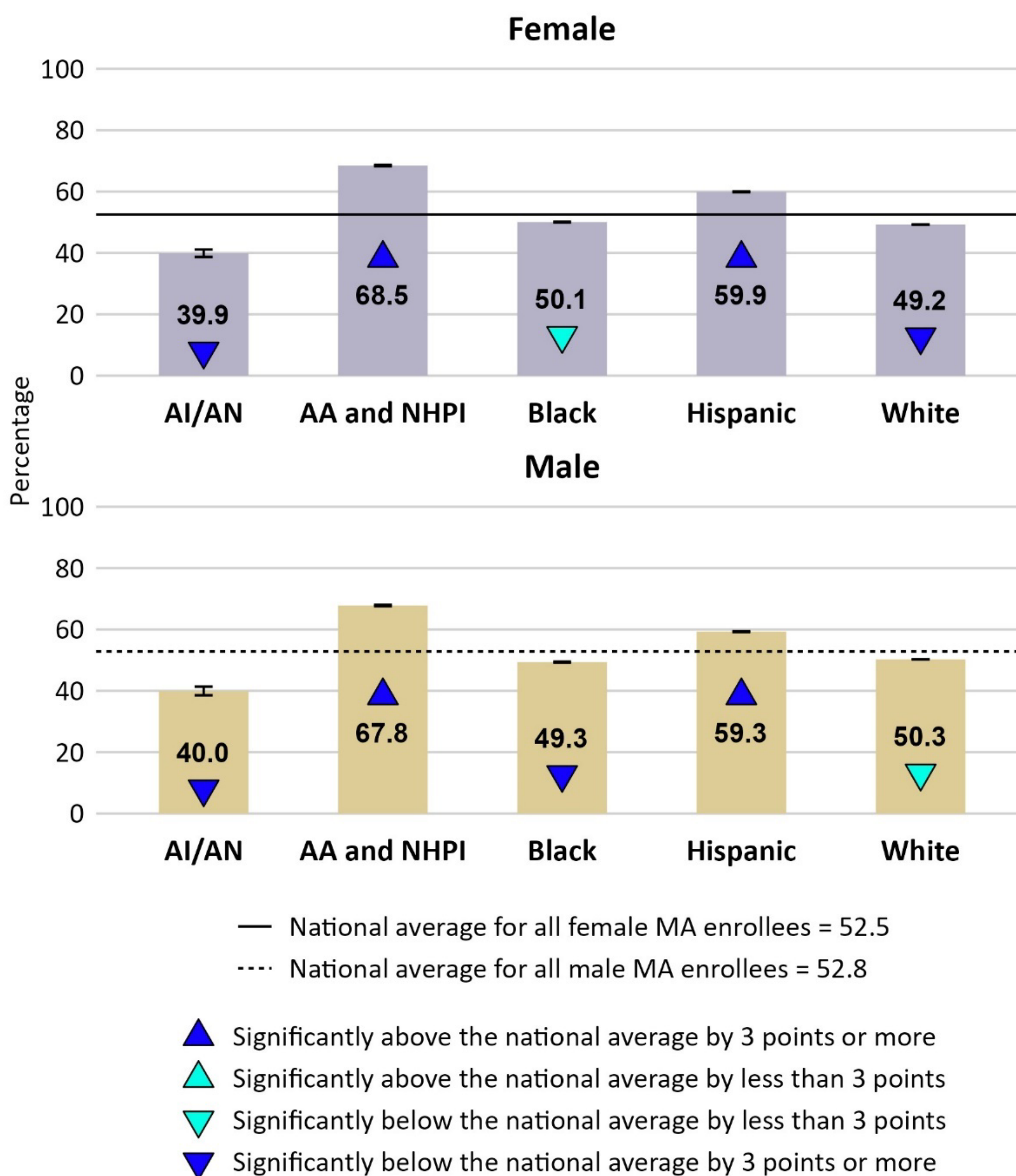
[†] Excludes those who also have clinical ASCVD.

Disparities

- The percentages of female AI/AN and Black MA enrollees who had proper statin medication adherence were each **below** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentage of female AA and NHPI MA enrollees who had proper statin medication adherence was **above** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentage of female Hispanic MA enrollees who had proper statin medication adherence was **below** the national average for all female MA enrollees with diabetes by less than 3 percentage points. The percentage of female White MA enrollees who had proper statin medication adherence was **above** the national average for all female MA enrollees with diabetes by less than 3 percentage points.
- The percentages of male AI/AN and Black MA enrollees who had proper statin medication adherence were each **below** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentages of male AA and NHPI and White MA enrollees who had proper statin medication adherence were each **above** the national average for all male MA enrollees with diabetes by less than 3 percentage points. The percentage of male Hispanic MA enrollees who had proper statin medication adherence was **below** the national average for all male MA enrollees with diabetes by less than 3 percentage points.

Kidney Health Evaluation for Patients with Diabetes

Percentage of MA enrollees aged 18 to 85 years with diabetes (type 1 and type 2) who received an annual kidney health evaluation,[†] by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

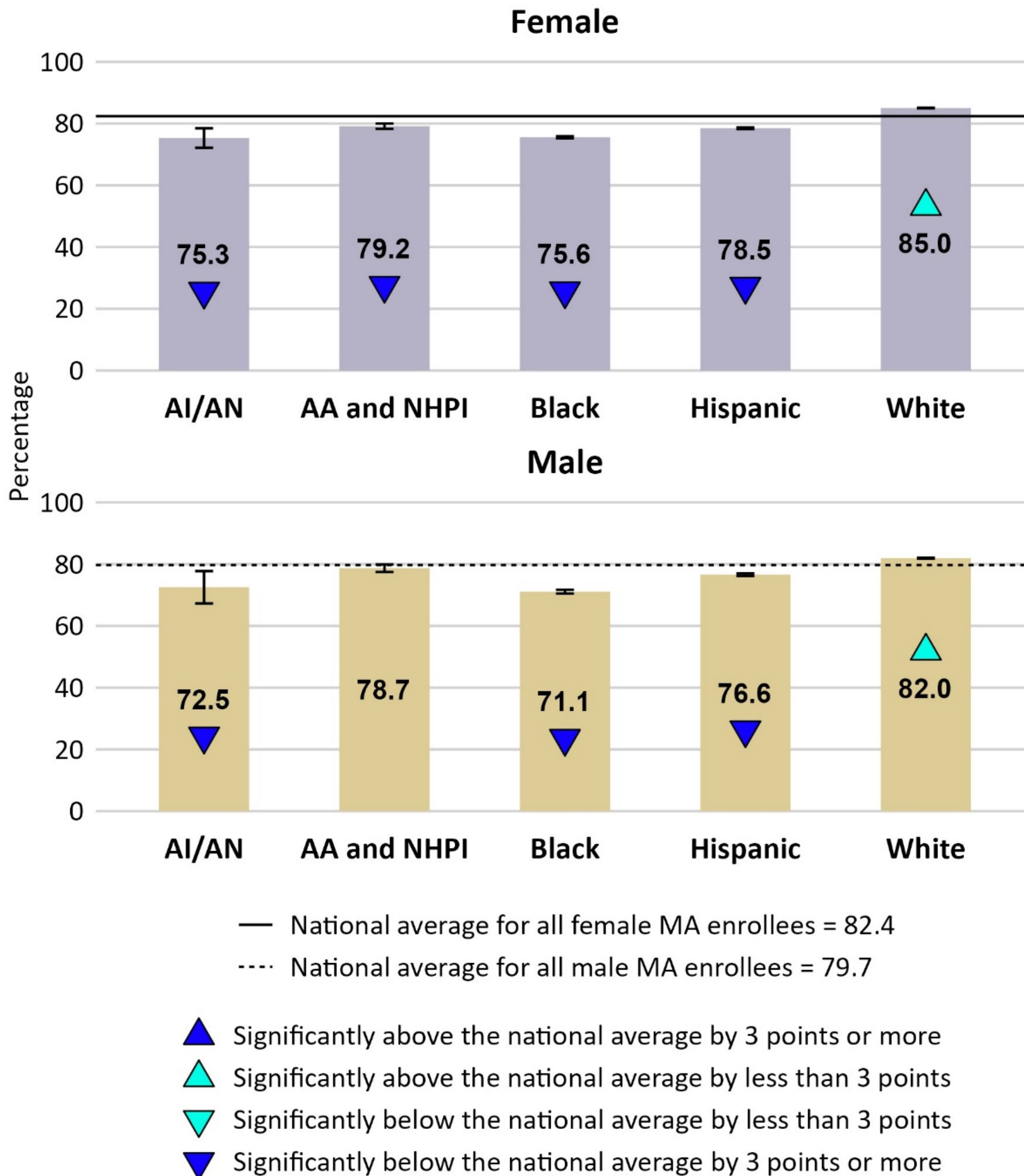
[†] Includes both an estimated glomerular filtration rate and a urine albumin-creatinine ratio.

Disparities

- The percentages of female AI/AN and White MA enrollees with diabetes who received an annual kidney health evaluation were each **below** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees with diabetes who received an annual kidney health evaluation were each **above** the national average for all female MA enrollees with diabetes by more than 3 percentage points. The percentage of female Black MA enrollees with diabetes who received an annual kidney health evaluation was **below** the national average for all female MA enrollees with diabetes by less than 3 percentage points.
- The percentages of male AI/AN and Black MA enrollees with diabetes who received an annual kidney health evaluation were each **below** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees with diabetes who received an annual kidney health evaluation were each **above** the national average for all male MA enrollees with diabetes by more than 3 percentage points. The percentage of male White MA enrollees with diabetes who received an annual kidney health evaluation was **below** the national average for all male MA enrollees with diabetes by less than 3 percentage points.

Antidepressant Medication Management—Acute Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 84 days, by race and ethnicity within sex, Reporting Year 2023



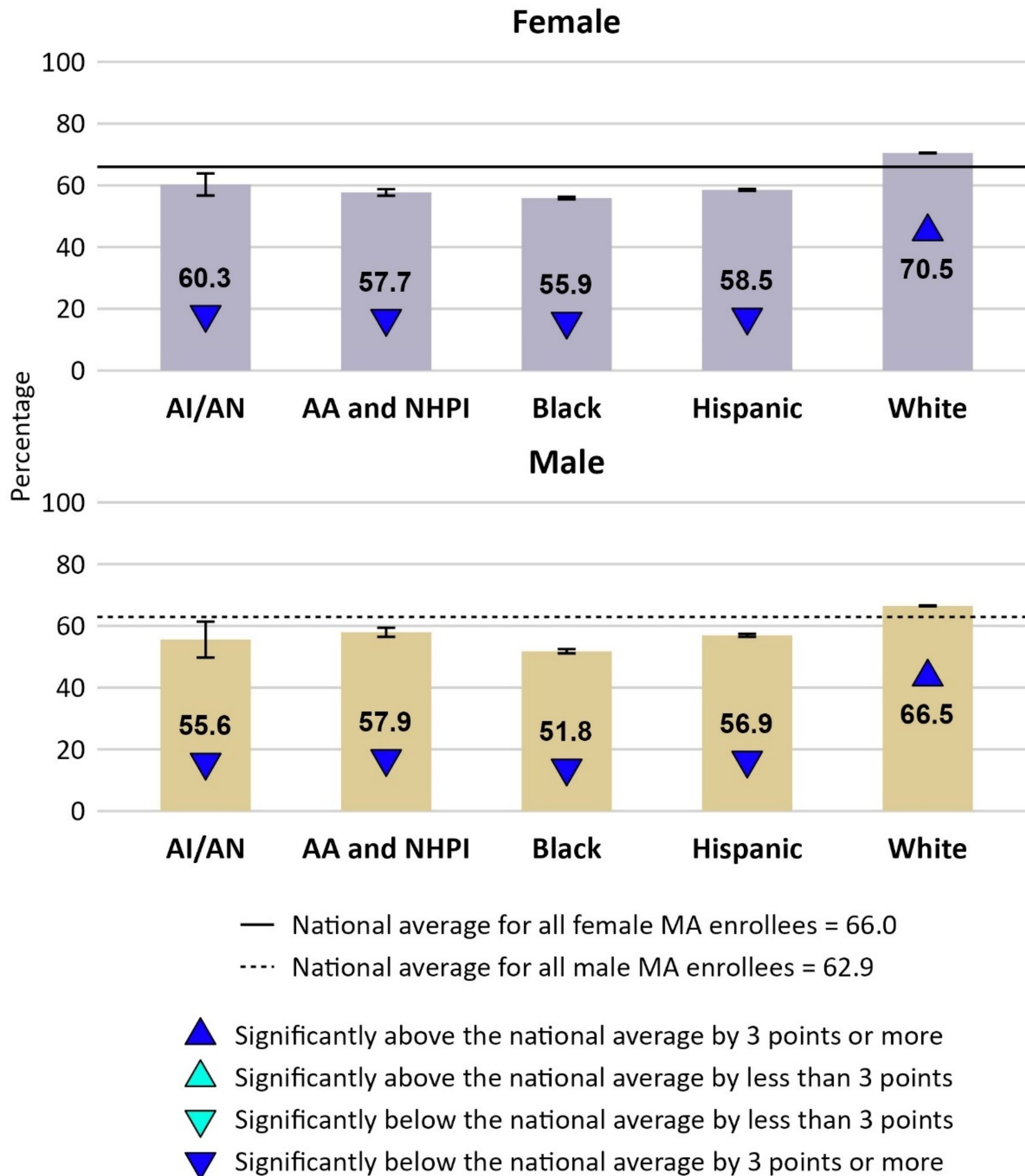
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of eligible female AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days were each **below** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentages of eligible male AI/AN, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days were each **below** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male AA and NHPI MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **similar to** the national average for all eligible male MA enrollees. The percentage of eligible male White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 84 days was **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Antidepressant Medication Management—Continuation Phase Treatment

Percentage of MA enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication and remained on the medication for at least 180 days, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.

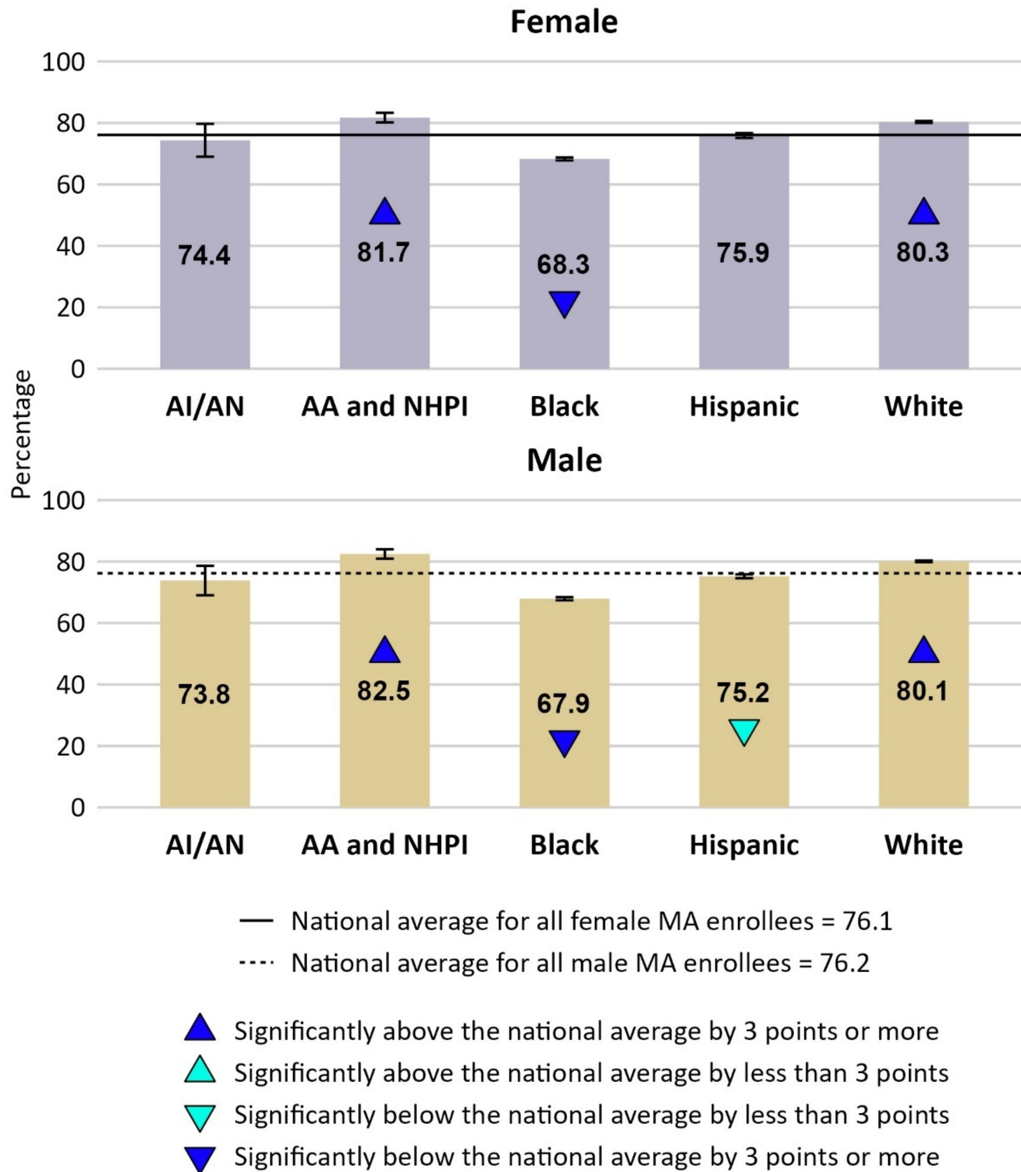
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of eligible female AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **below** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of eligible female White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentages of eligible male AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days were each **below** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of eligible male White MA enrollees who were newly treated with antidepressant medication and remained on the medication for at least 180 days was **above** the national average for all eligible male MA enrollees by more than 3 percentage points.

Adherence to Antipsychotic Medications for People with Schizophrenia

Percentage of MA enrollees aged 18 years and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period, by race and ethnicity within sex, Reporting Year 2023



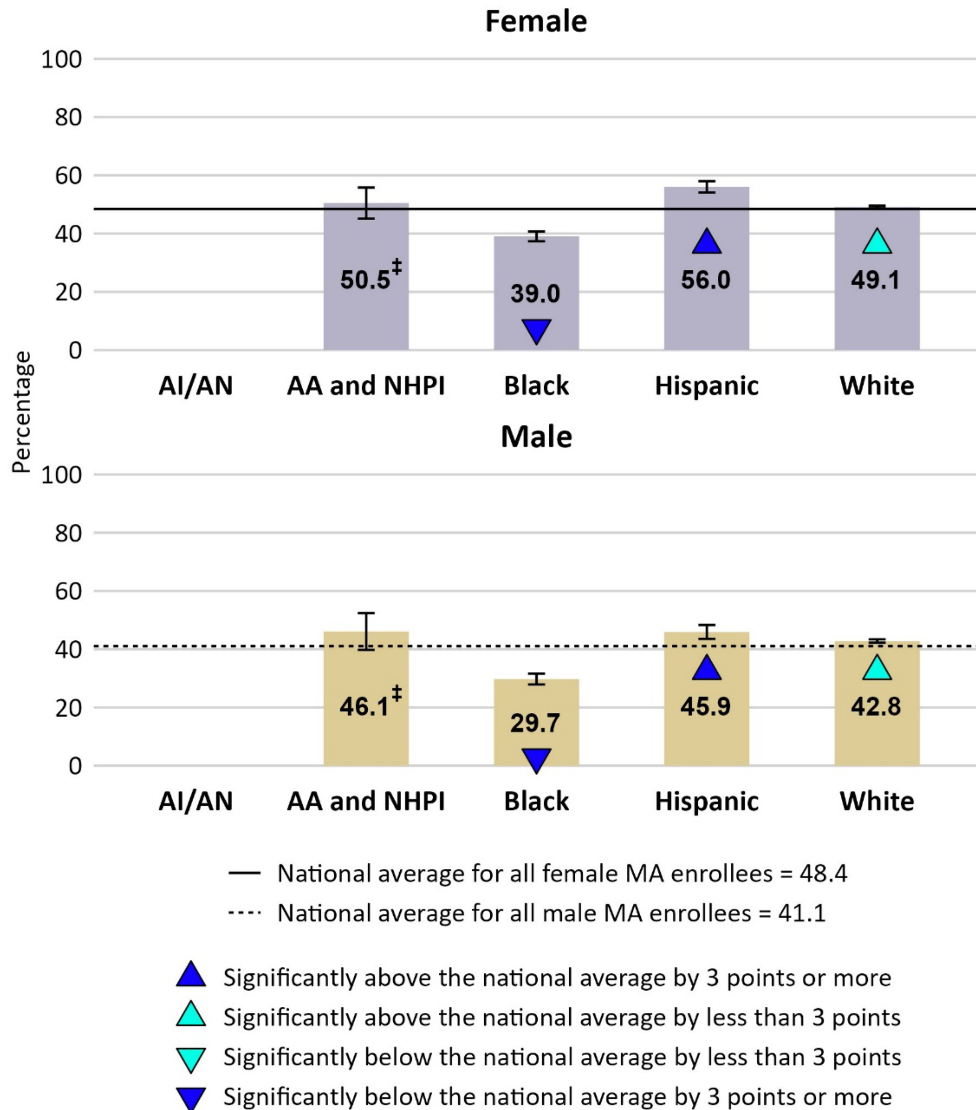
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of female AI/AN and Hispanic MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period were each **similar to** the national average for all female MA enrollees with schizophrenia or schizoaffective disorder. The percentages of female AA and NHPI and White MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period were each **above** the national average for all female MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points. The percentage of female Black MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **below** the national average for all female MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points.
- The percentage of male AI/AN MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **similar to** the national average for all male MA enrollees with schizophrenia or schizoaffective disorder. The percentages of male AA and NHPI and White MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period were each **above** the national average for all male MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points. The percentage of male Black MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **below** the national average for all male MA enrollees with schizophrenia or schizoaffective disorder by more than 3 percentage points. The percentage of male Hispanic MA enrollees with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period was **below** the national average for all male MA enrollees with schizophrenia or schizoaffective disorder by less than 3 percentage points.

Follow-Up After Hospital Stay for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older[†] who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

‡ This score is based on fewer than 400 completed measures, and thus its accuracy might be low.

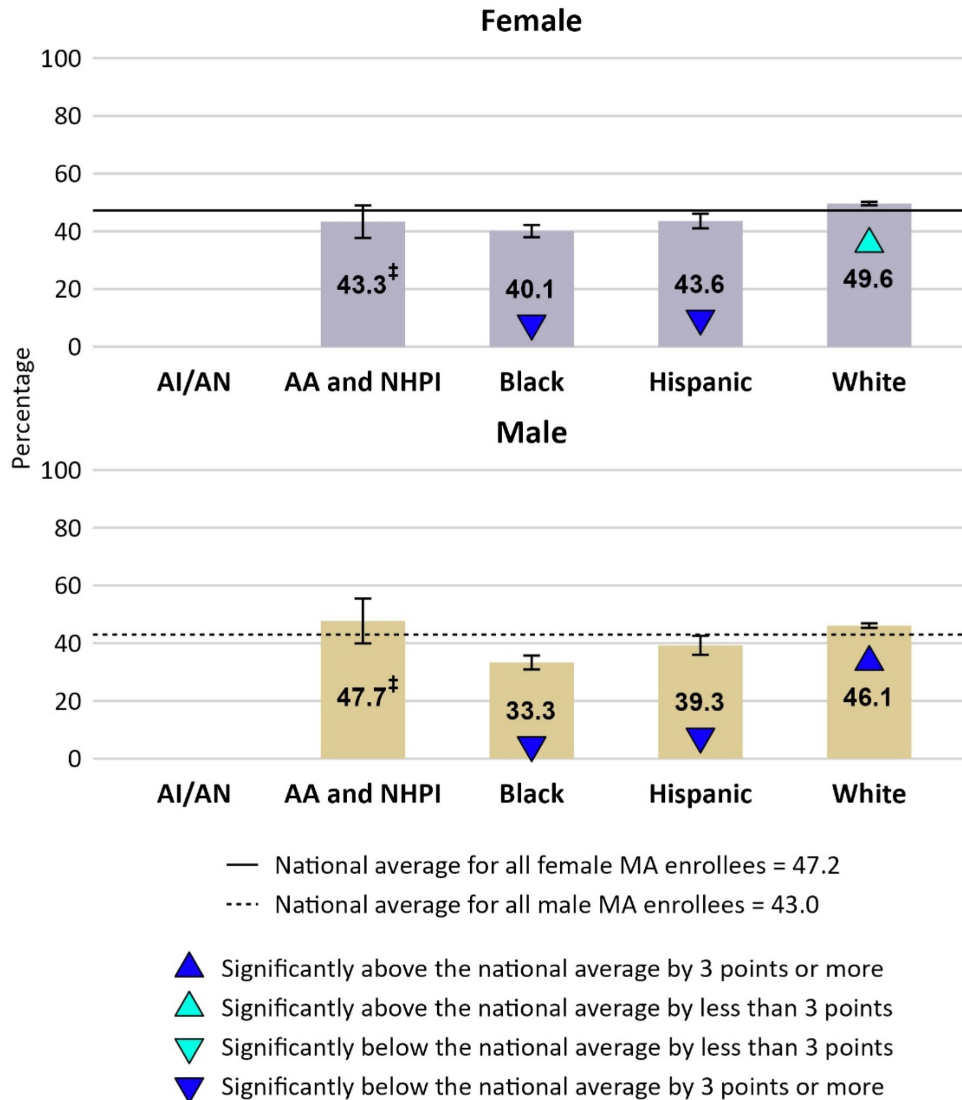
† Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to adults.

Disparities

- The percentage of older adult female AA and NHPI MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible older adult female MA enrollees. The percentage of older adult female Black MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female Hispanic MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentage of older adult male AA and NHPI MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **similar to** the national average for all eligible older adult male MA enrollees. The percentage of older adult male Black MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male Hispanic MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees who were hospitalized for a mental health disorder who had appropriate follow-up care within 30 days of discharge was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for Mental Illness (within 30 days of discharge)

Percentage of MA enrollees aged 65 years and older[†] who had an ED visit for selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of the ED visit, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

‡ This score is based on fewer than 400 completed measures, and thus its accuracy might be low.

---

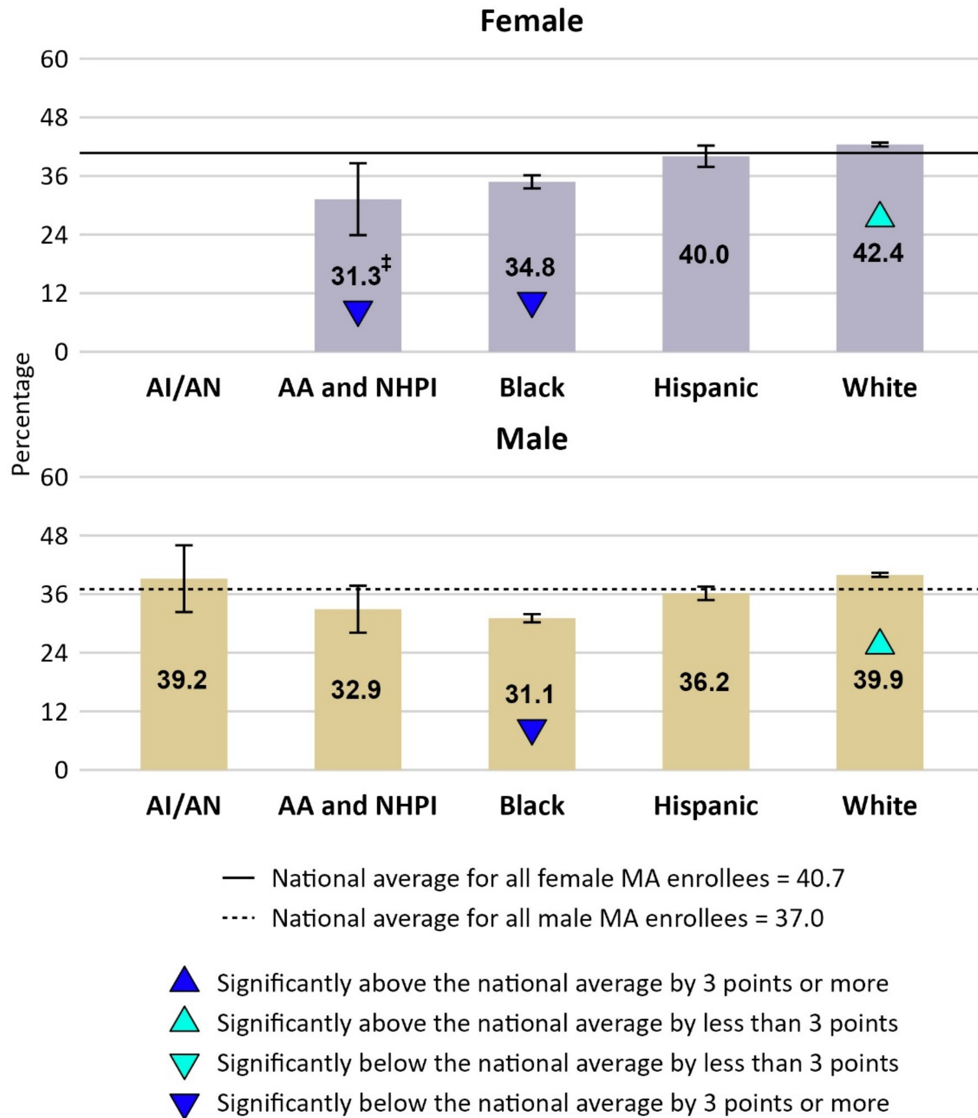
† Although the lower-bound age cutoff for this HEDIS measure is six years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult female AA and NHPI MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **similar to** the national average for all eligible older adult female MA enrollees. The percentages of older adult female Black and Hispanic MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit were each **below** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentage of older adult male AA and NHPI MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **similar to** the national average for all eligible older adult male MA enrollees. The percentages of older adult male Black and Hispanic MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit were each **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees who had an ED visit for a mental health disorder who had a follow-up visit with a mental health practitioner within 30 days of the ED visit was **above** the national average for all eligible older adult male MA enrollees by more than 3 percentage points.

Follow-Up After ED Visit for AOD Abuse or Dependence (within 30 days of discharge)

Percentage of MA enrollees aged 18 years and older† who had an ED visit for AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit, by race and ethnicity within sex, Reporting Year 2023



— National average for all female MA enrollees = 40.7

---- National average for all male MA enrollees = 37.0

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The score for female AI/AN MA enrollees is not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

‡ This score is based on fewer than 400 completed measures, and thus its accuracy might be low.

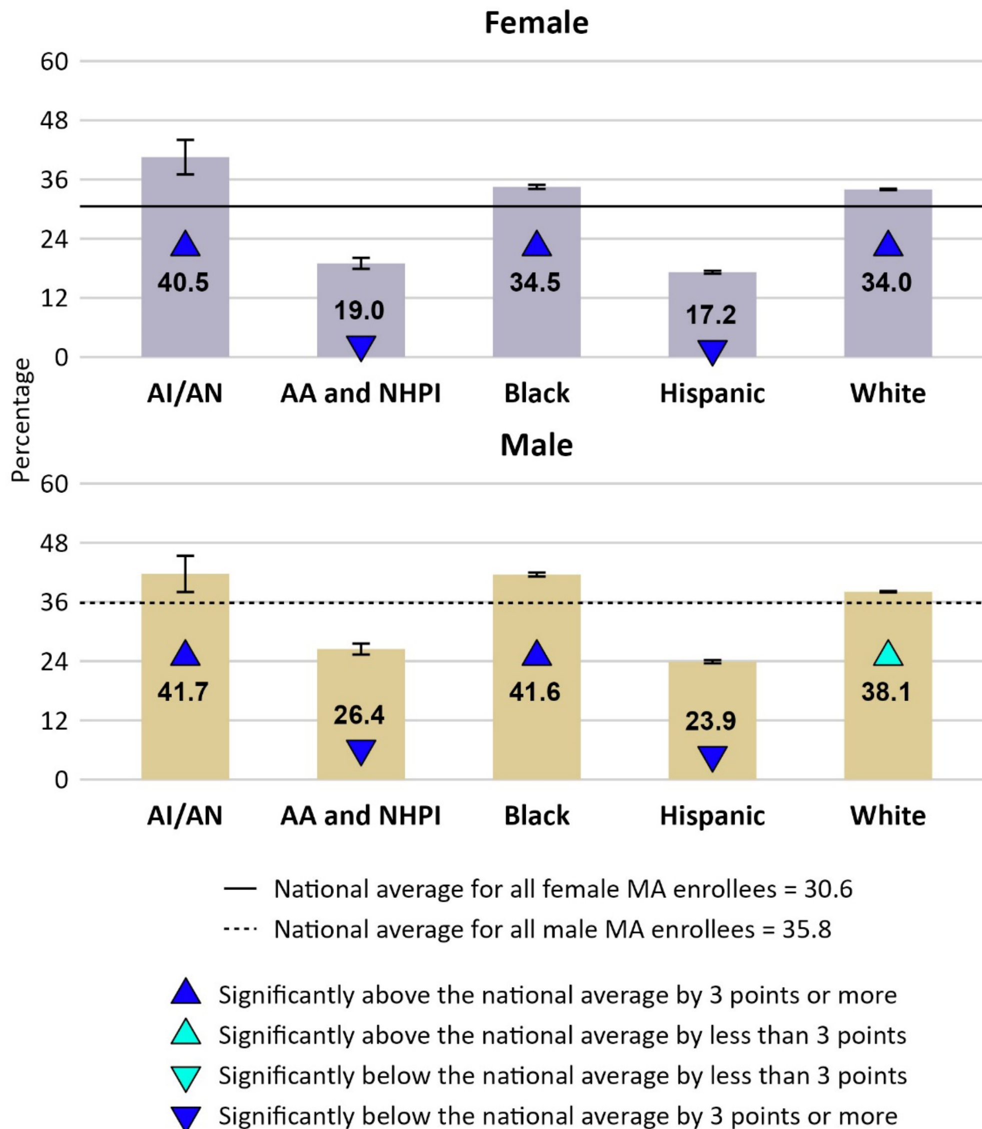
† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Disparities

- The percentages of female AA and NHPI and Black MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence were each **below** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentage of female Hispanic MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **similar to** the national average for all eligible female MA enrollees. The percentage of female White MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentages of male AI/AN, AA and NHPI, and Hispanic MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence were each **similar to** the national average for all eligible male MA enrollees. The percentage of male Black MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **below** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees who had a follow-up visit for AOD abuse or dependence within 30 days of an ED visit for AOD abuse or dependence was **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Initiation of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older† with a new episode of AOD dependence who initiated‡ treatment within 14 days of the diagnosis, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

---

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

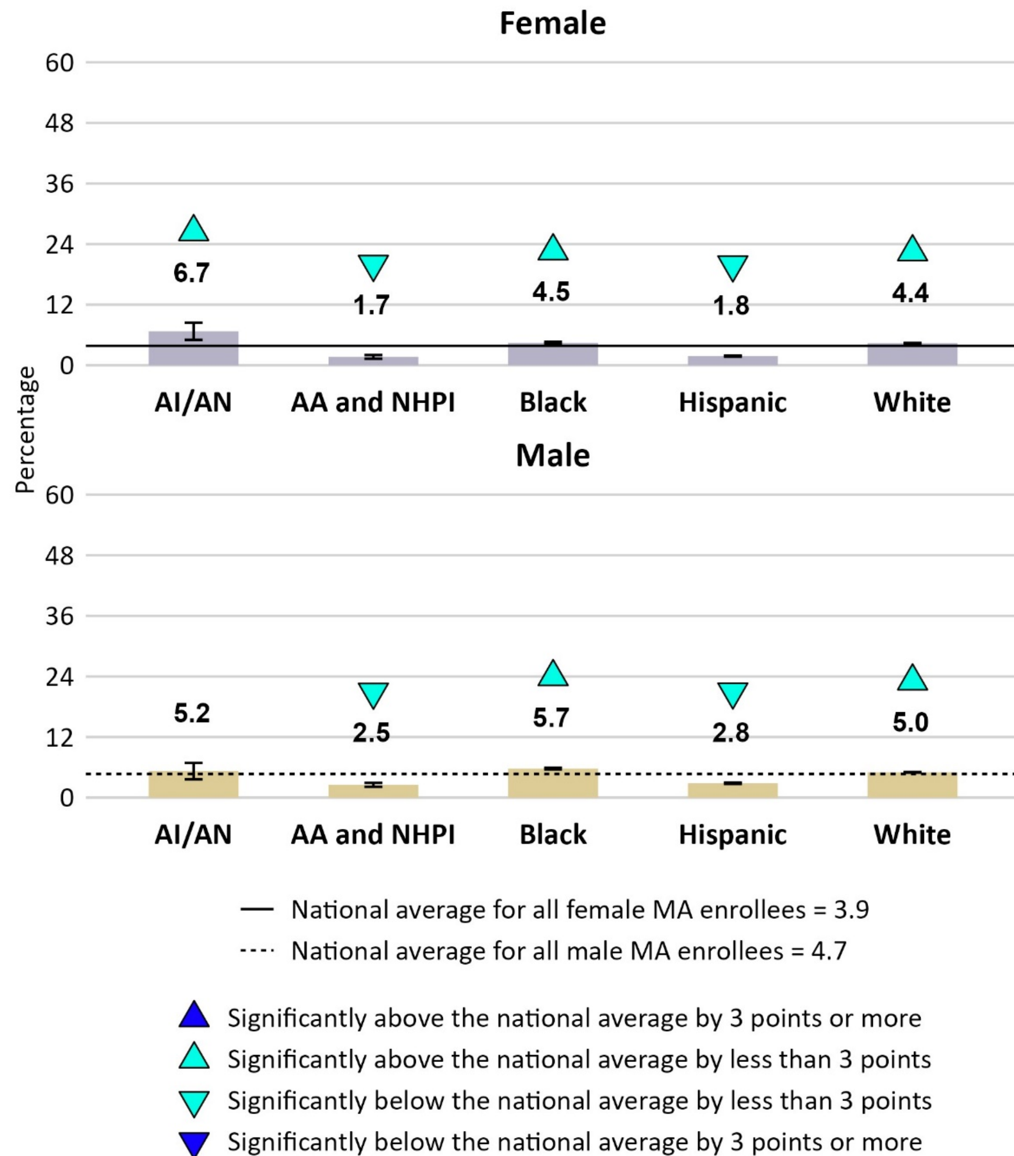
‡ Initiation may occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Disparities

- The percentages of female AI/AN, Black, and White MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **above** the national average for all eligible female MA enrollees by more than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **below** the national average for all eligible female MA enrollees by more than 3 percentage points.
- The percentages of male AI/AN and Black MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **above** the national average for all eligible male MA enrollees by more than 3 percentage points. The percentages of male AA and NHPI and Hispanic MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence were each **below** the national average for all male eligible MA enrollees by more than 3 percentage points. The percentage of male White MA enrollees who initiated treatment within 14 days of a diagnosis of AOD dependence was **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Engagement of AOD Dependence Treatment

Percentage of MA enrollees aged 18 years and older† with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

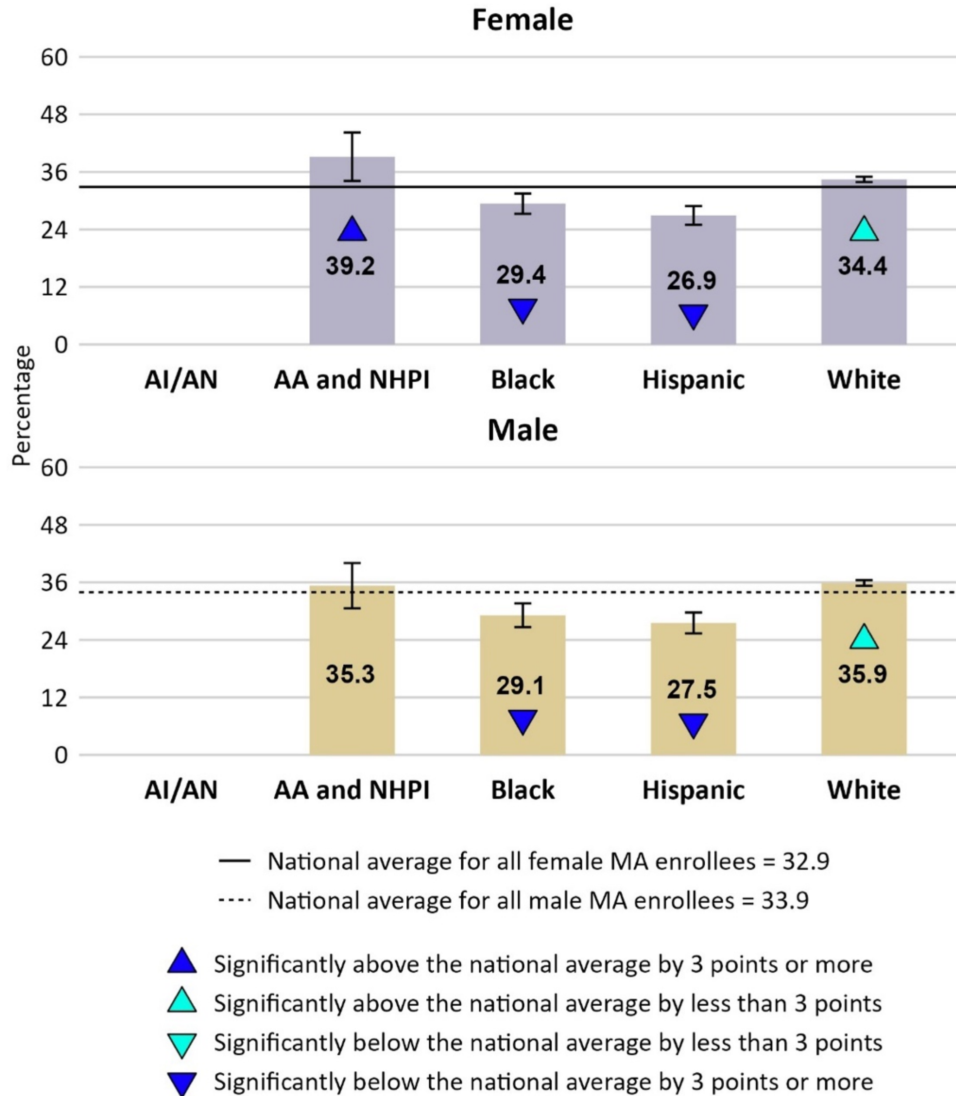
Disparities

- The percentages of female AI/AN, Black, and White MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **above** the national average for all eligible female MA enrollees by less than 3 percentage points. The percentages of female AA and NHPI and Hispanic MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **below** the national average for all eligible female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment was **similar to** the national average for all eligible male MA enrollees. The percentages of male AA and NHPI and Hispanic MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **below** the national average for all eligible male MA enrollees by less than 3 percentage points. The percentages of male Black and White MA enrollees with a new episode of AOD dependence who had two or more additional services within 30 days of initiating AOD dependence treatment were each **above** the national average for all eligible male MA enrollees by less than 3 percentage points.

Clinical Care: Medication Management and Care Coordination

Transitions of Care—Notification of Inpatient Admission

Percentage of MA enrollees aged 65 years and older[†] who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

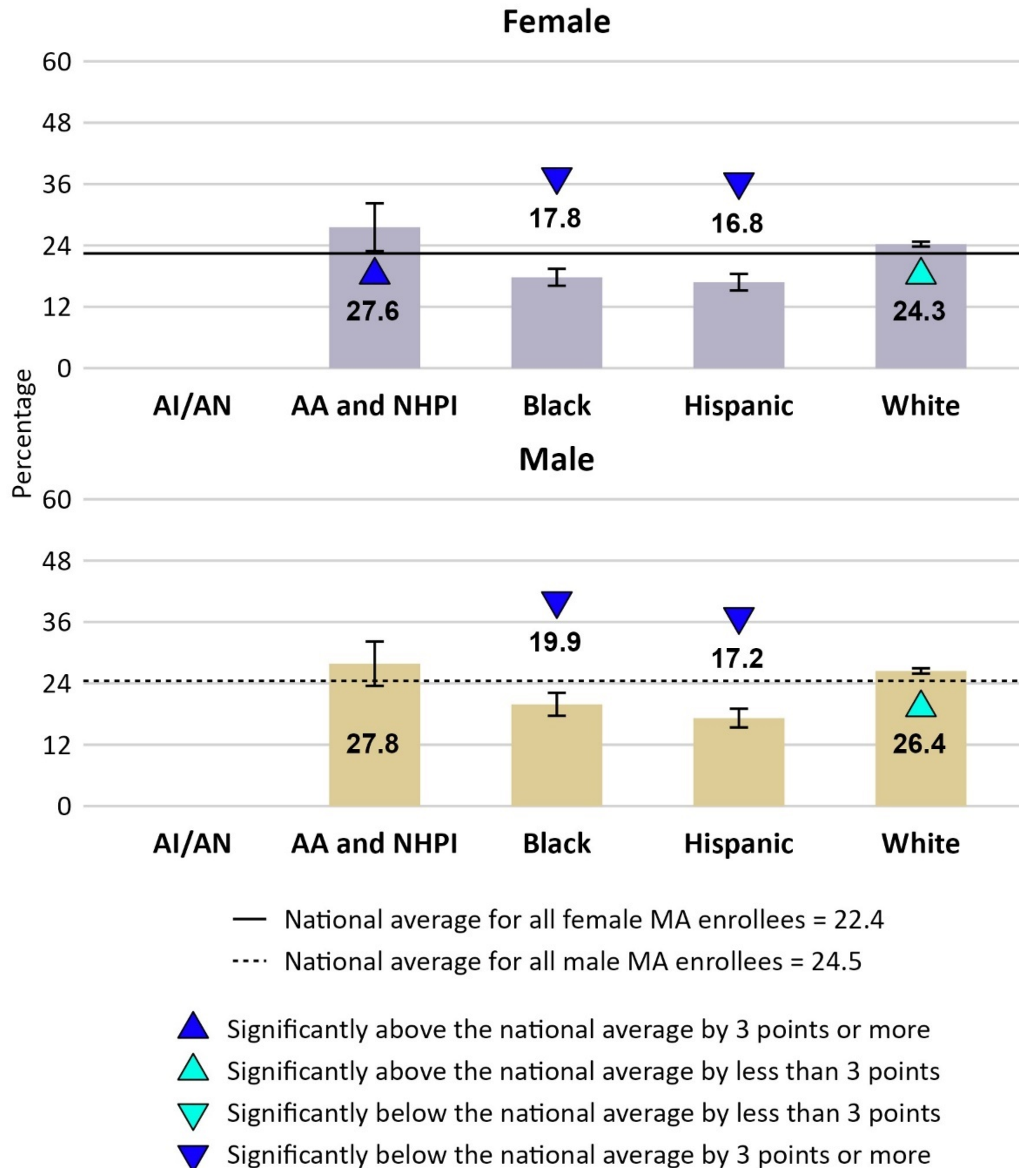
[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult female AA and NHPI MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentages of older adult female Black and Hispanic MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission were each **below** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentage of older adult male AA and NHPI MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **similar to** the national average for all eligible older adult male MA enrollees. The percentages of older adult male Black and Hispanic MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission were each **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees who were discharged from an inpatient facility whose primary or ongoing care providers were notified of the inpatient admission on the day of or the day following admission was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Transitions of Care—Receipt of Discharge Information

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility who received discharge information on the day of or the day following discharge, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

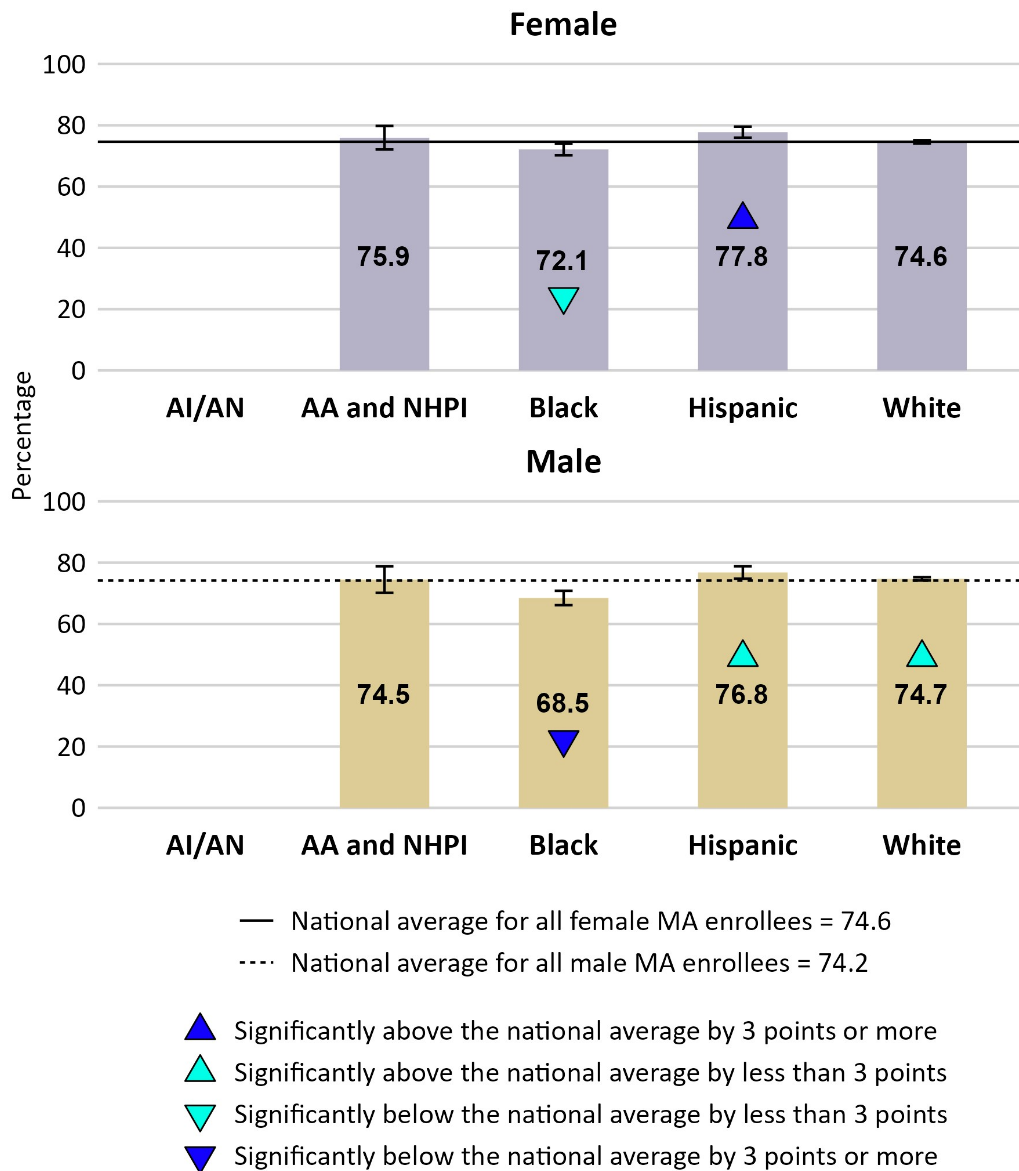
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentage of older adult female AA and NHPI MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentages of older adult female Black and Hispanic MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility were each **below** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentage of older adult male AA and NHPI MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **similar to** the national average for all eligible older adult male MA enrollees. The percentages of older adult male Black and Hispanic MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility were each **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees who received discharge information on the day of or the day following discharge from an inpatient facility was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Transitions of Care—Medication Reconciliation After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility for whom medications were reconciled within 30 days of discharge, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

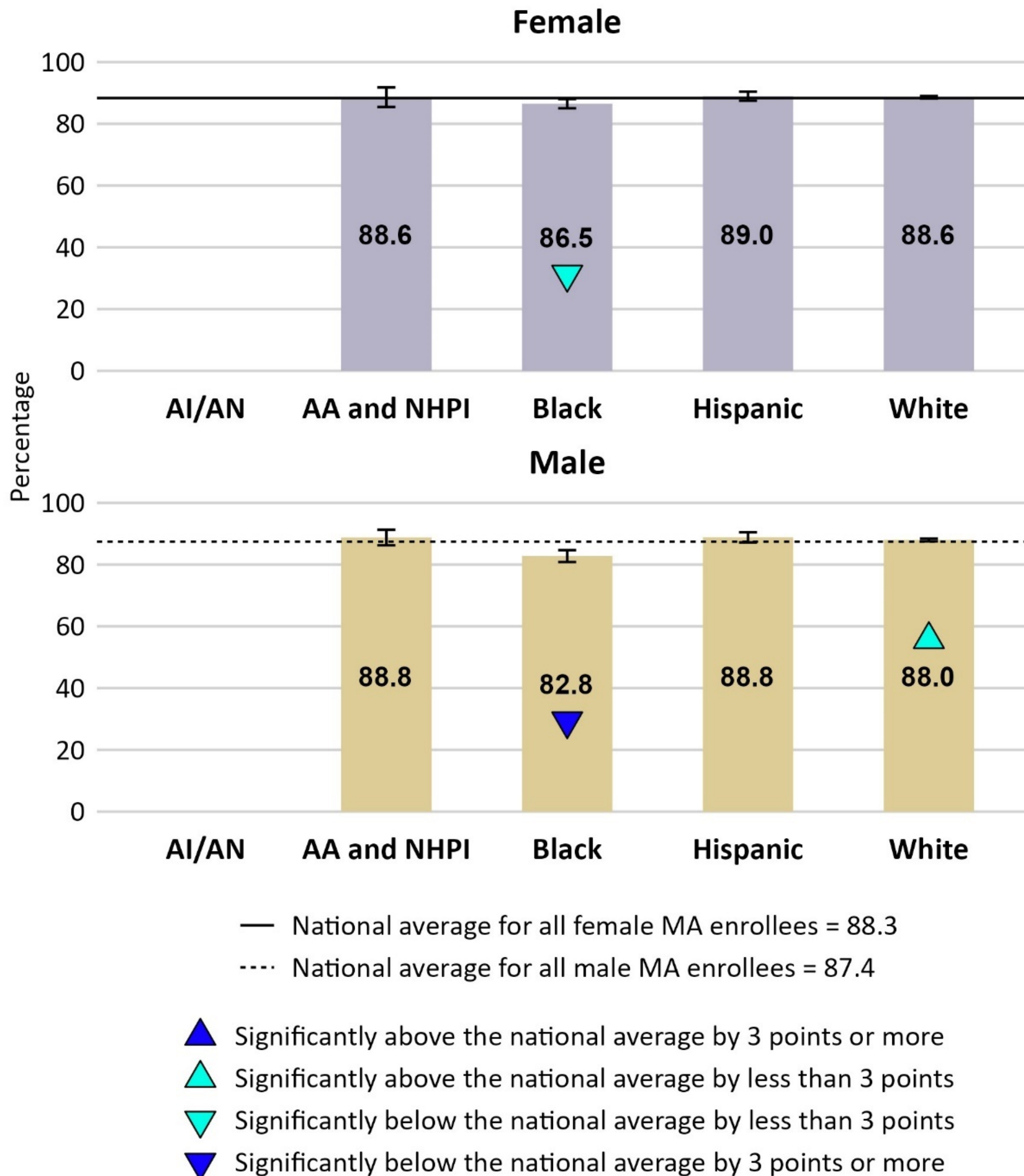
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentages of older adult female AA and NHPI and White MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible older adult female MA enrollees. The percentage of older adult female Black MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult female MA enrollees by less than 3 points. The percentage of older adult female Hispanic MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult female MA enrollees by more than 3 percentage points.
- The percentage of older adult male AA and NHPI MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **similar to** the national average for all eligible older adult male MA enrollees. The percentage of older adult male Black MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentages of older adult male Hispanic and White MA enrollees who had their medications reconciled within 30 days of discharge from an inpatient facility were each **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Transitions of Care—Patient Engagement After Inpatient Discharge

Percentage of MA enrollees aged 65 years and older† who were discharged from an inpatient facility for whom patient engagement (office visit, home visit, telehealth) was provided within 30 days of discharge, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN MA enrollees are not accurate enough to report.

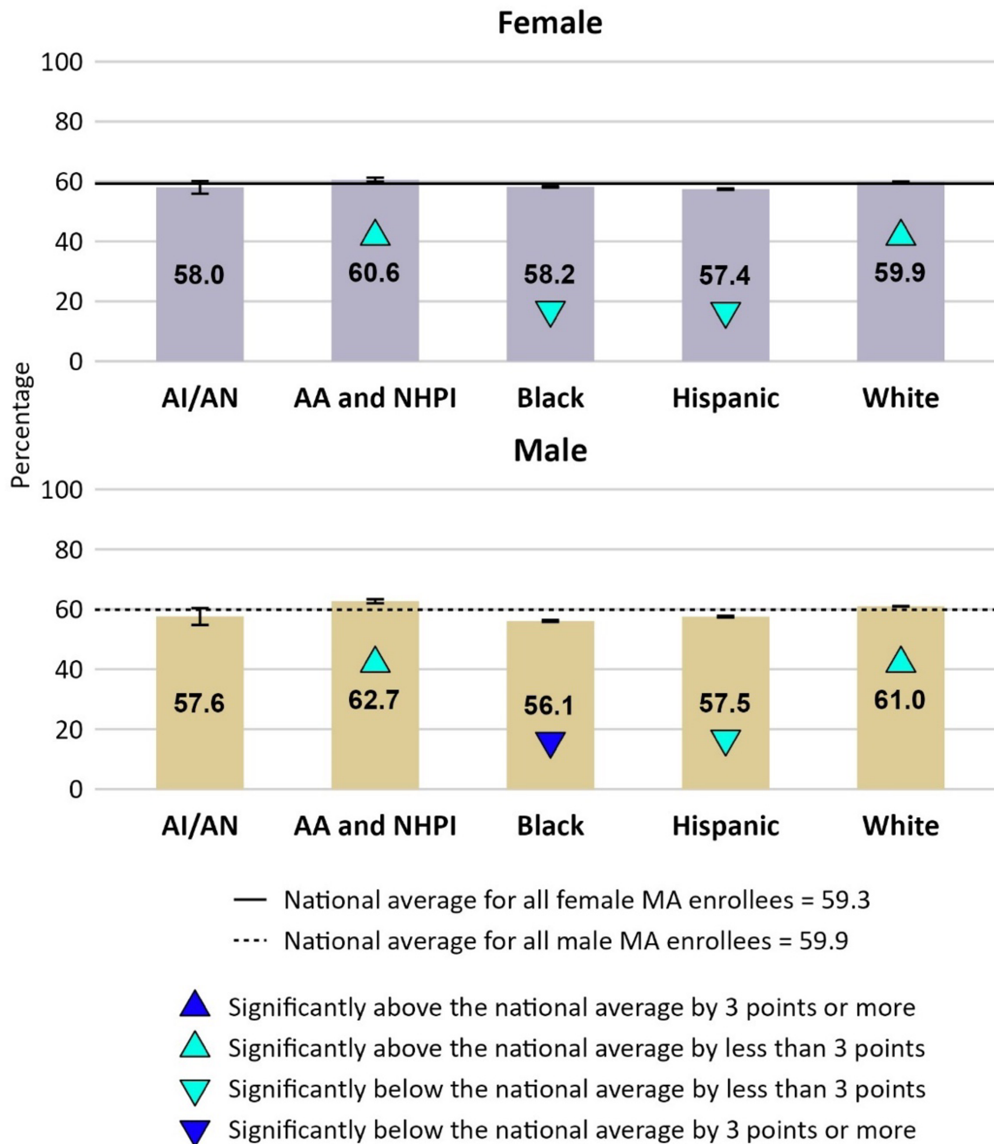
† Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

Disparities

- The percentages of older adult female AA and NHPI, Hispanic, and White MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible older adult female MA enrollees. The percentage of older adult female Black MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentages of older adult male AA and NHPI and Hispanic MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility were each **similar to** the national average for all eligible older adult male MA enrollees. The percentage of older adult male Black MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees who had an office visit, had a home visit, or received telehealth services within 30 days of discharge from an inpatient facility was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions

Percentage of MA enrollees aged 65 years and older[†] with multiple high-risk chronic conditions[‡] who received follow-up care within seven days of an ED visit, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

[†] Although the lower-bound age cutoff for this HEDIS measure is 18 years old, the data used in this report are limited to older adults.

[‡] Conditions include COPD and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, AMI, atrial fibrillation, and stroke and transient ischemic attack.

Disparities

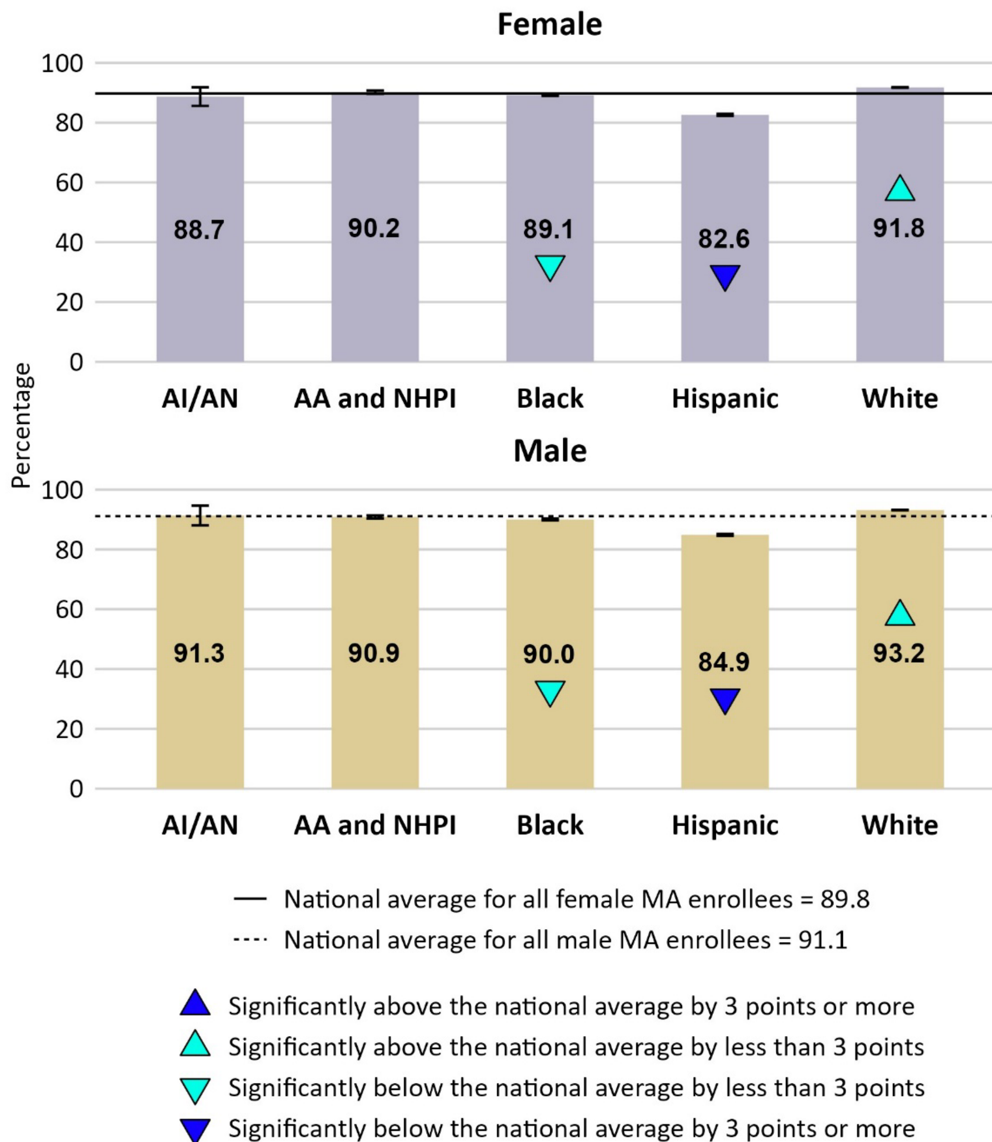
- The percentage of older adult female AI/AN MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **similar to** the national average for all eligible older adult female MA enrollees. The percentages of older adult female AA and NHPI and White MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit were each **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points. The percentages of older adult female Black and Hispanic MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit were each **below** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.

- The percentage of older adult male AI/AN MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **similar to** the national average for all eligible older adult male MA enrollees. The percentages of older adult male AA and NHPI and White MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit were each **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points. The percentage of older adult male Black MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male Hispanic MA enrollees with multiple high-risk chronic conditions who received follow-up care within seven days of an ED visit was **below** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Clinical Care: Overuse and Appropriate Use of Medication

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Chronic Renal Failure

Percentage of MA enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

---

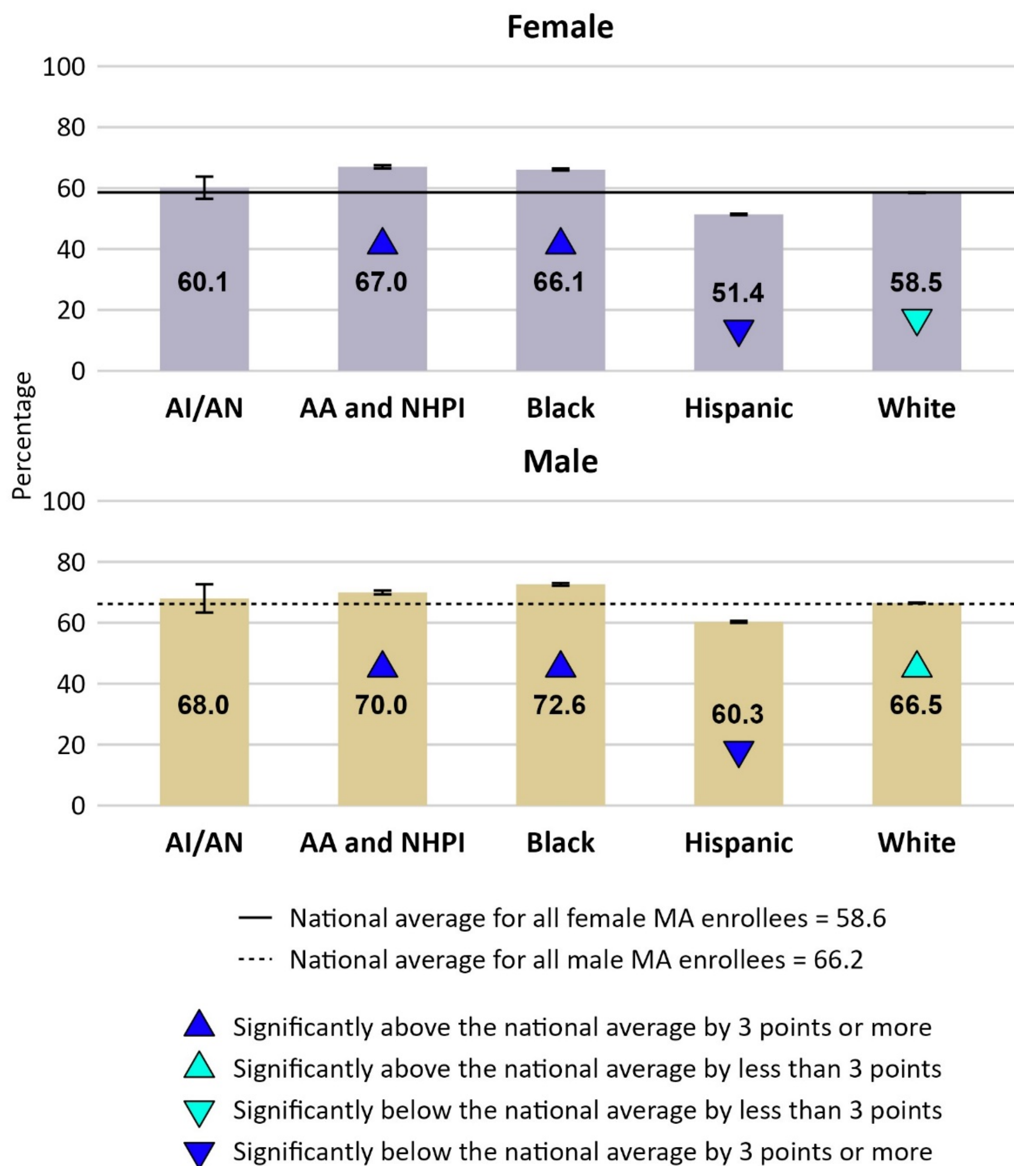
† This includes cyclooxygenase-2 selective NSAIDs or nonaspirin NSAIDs.

Disparities

- The percentages of older adult female AI/AN and AA and NHPI MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided were each **similar to** the national average for all eligible older adult female MA enrollees. The percentage of older adult female Black MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult female MA enrollees by less than 3 percentage points. The percentage of older adult female Hispanic MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentages of older adult male AI/AN and AA and NHPI MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided were each **similar to** the national average for all eligible older adult male MA enrollees. The percentage of older adult male Black MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult male MA enrollees by less than 3 percentage points. The percentage of older adult male Hispanic MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees with chronic renal failure for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with Dementia

Percentage of MA enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,[†] by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

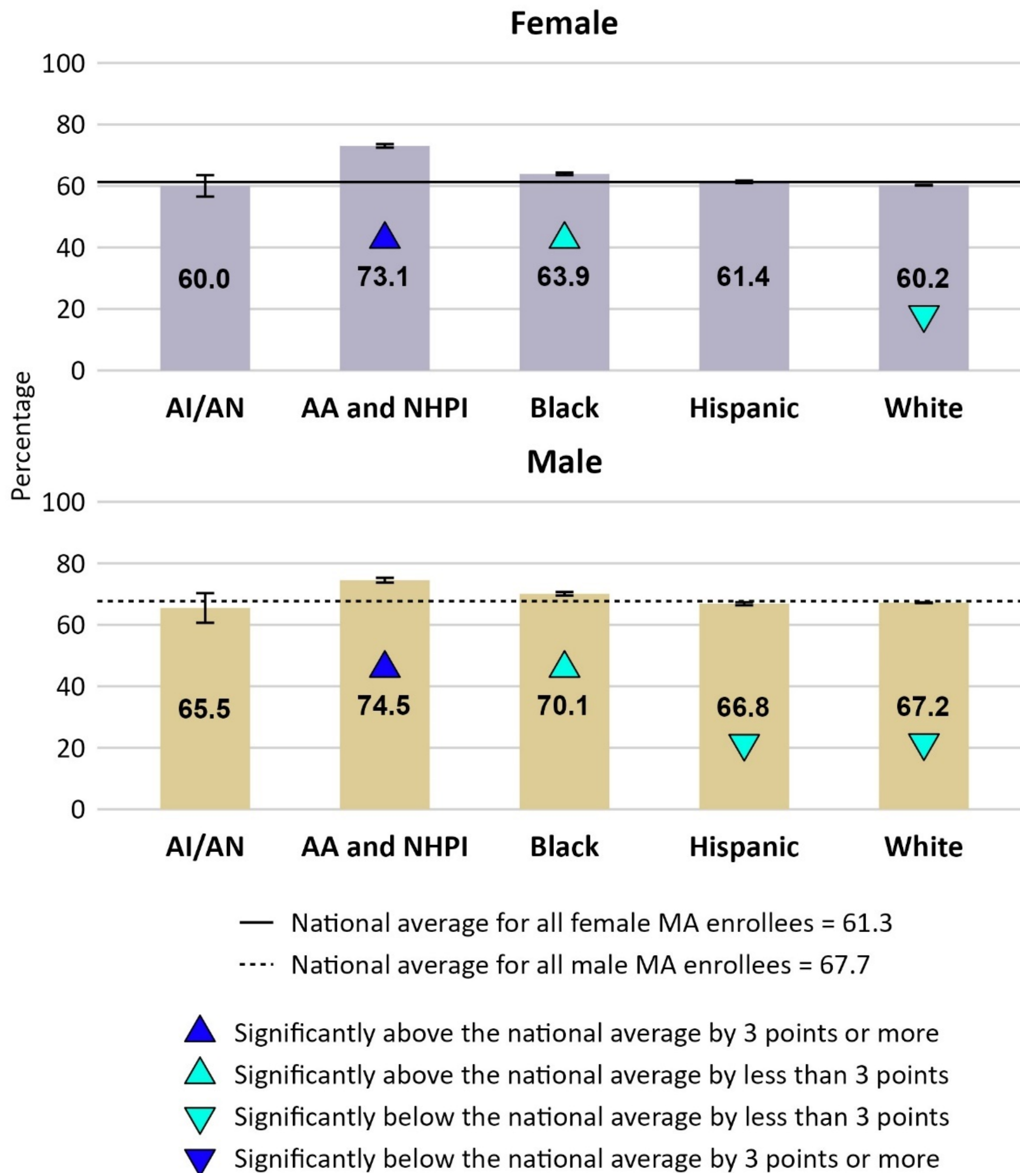
[†] This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Disparities

- The percentage of older adult female AI/AN MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult female MA enrollees. The percentages of older adult female AA and NHPI and Black MA enrollees with dementia for whom use of potentially harmful medication was avoided were each **above** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female Hispanic MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female White MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentage of older adult male AI/AN MA enrollees with dementia for whom use of potentially harmful medication was avoided was **similar to** the national average for eligible older adult all male MA enrollees. The percentages of older adult male AA and NHPI and Black MA enrollees with dementia for whom use of potentially harmful medication was avoided were each **above** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male Hispanic MA enrollees with dementia for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male White MA enrollees with dementia for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Avoiding Potentially Harmful Drug-Disease Interactions in Older Adult Patients with a History of Falls

Percentage of MA enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

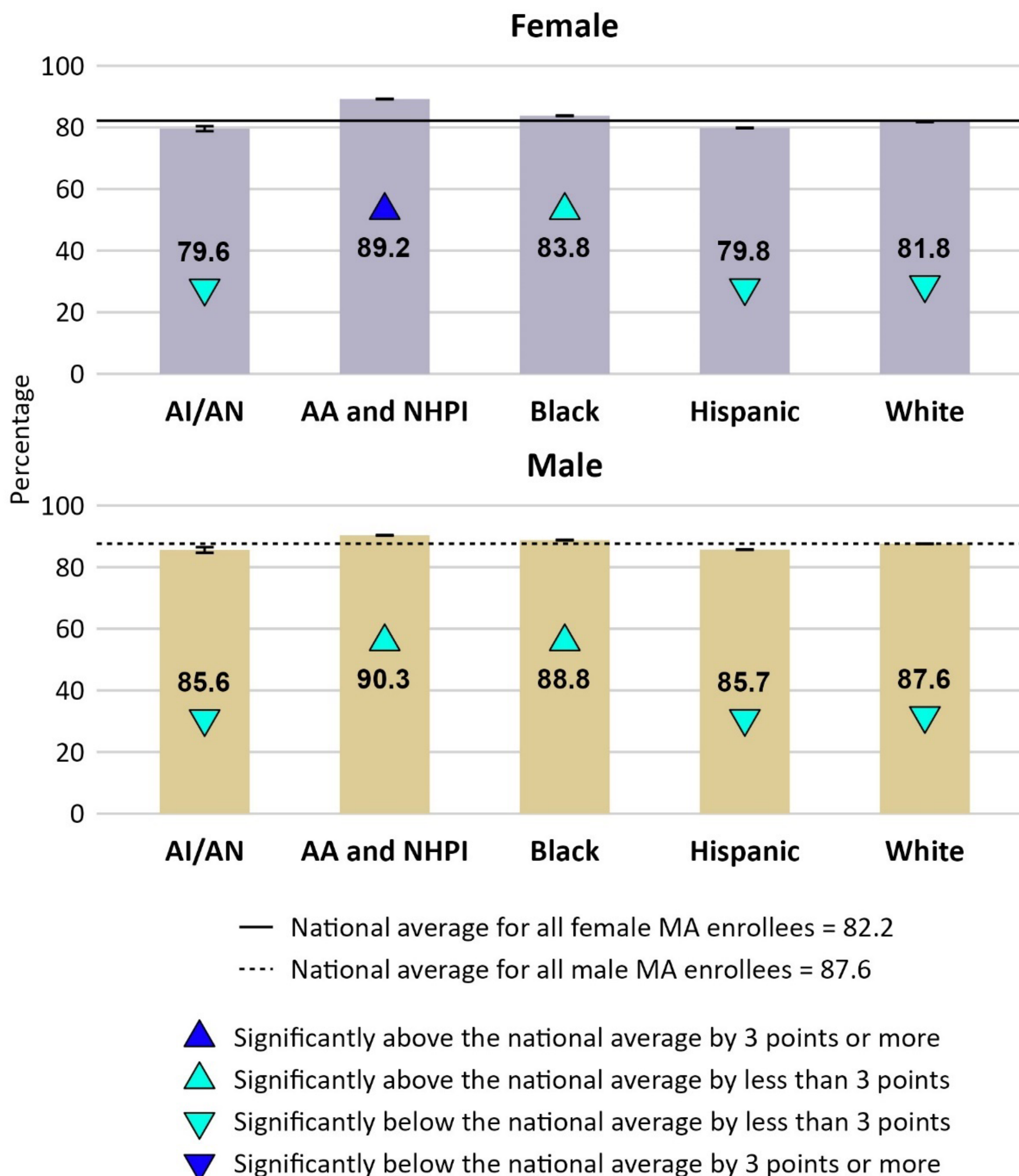
† This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin reuptake inhibitors, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Disparities

- The percentages of older adult female AI/AN and Hispanic MA enrollees with a history of falls for whom use of potentially harmful medication was avoided were each **similar to** the national average for all eligible older adult female MA enrollees. The percentage of older adult female AA and NHPI MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female Black MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult female MA enrollees by less than 3 percentage points. The percentage of older adult female White MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **below** the national average for all eligible older adult female MA enrollees by less than 3 percentage points.
- The percentage of older adult male AI/AN MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **similar to** the national average for all eligible older adult male MA enrollees. The percentage of older adult male AA and NHPI MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult male MA enrollees by more than 3 percentage points. The percentage of older adult male Black MA enrollees with a history of falls for whom use of potentially harmful medication was avoided was **above** the national average for all eligible older adult male MA enrollees by less than 3 percentage points. The percentages of older adult male Hispanic and White MA enrollees with a history of falls for whom use of potentially harmful medication was avoided were each **below** the national average for all eligible older adult male MA enrollees by less than 3 percentage points.

Avoiding Use of High-Risk Medications in Older Adults

Percentage of MA enrollees aged 65 years and older who were not prescribed two or more high-risk medications from the same drug class in the past year, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

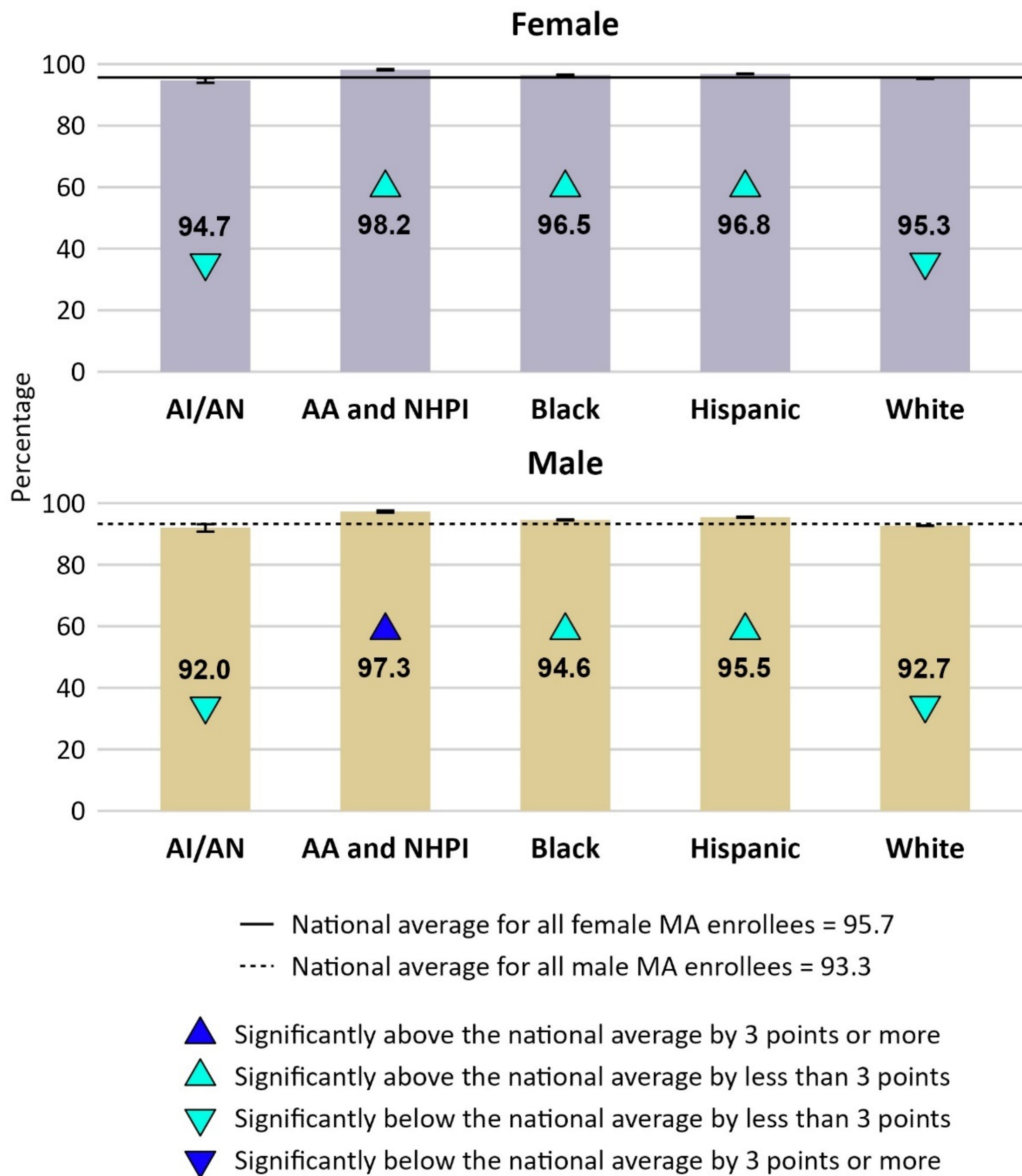
Disparities

- The percentages of older adult female AI/AN, Hispanic, and White MA enrollees for whom use of high-risk medications was avoided were each **below** the national average for all older adult female MA enrollees by less than 3 percentage points. The percentage of older adult female AA and NHPI MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all older adult female MA enrollees by more than 3 percentage points. The percentage of older adult female Black MA enrollees for whom use of high-risk medications was avoided was **above** the national average for all older adult female MA enrollees by less than 3 percentage points.
- The percentages of older adult male AI/AN, Hispanic, and White MA enrollees for whom use of high-risk medications was avoided were each **below** the national average for all older adult male MA enrollees by less than 3 percentage points.[†] The percentages of older adult male AA and NHPI and Black MA enrollees for whom use of high-risk medications was avoided were each **above** the national average for all older adult male MA enrollees by less than 3 percentage points.

[†] Prior to rounding.

Avoiding Use of Opioids at High Dosage

Percentage of MA enrollees aged 18 years and older who were not prescribed opioids at a high dosage[†] for more than 14 days in the past year, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

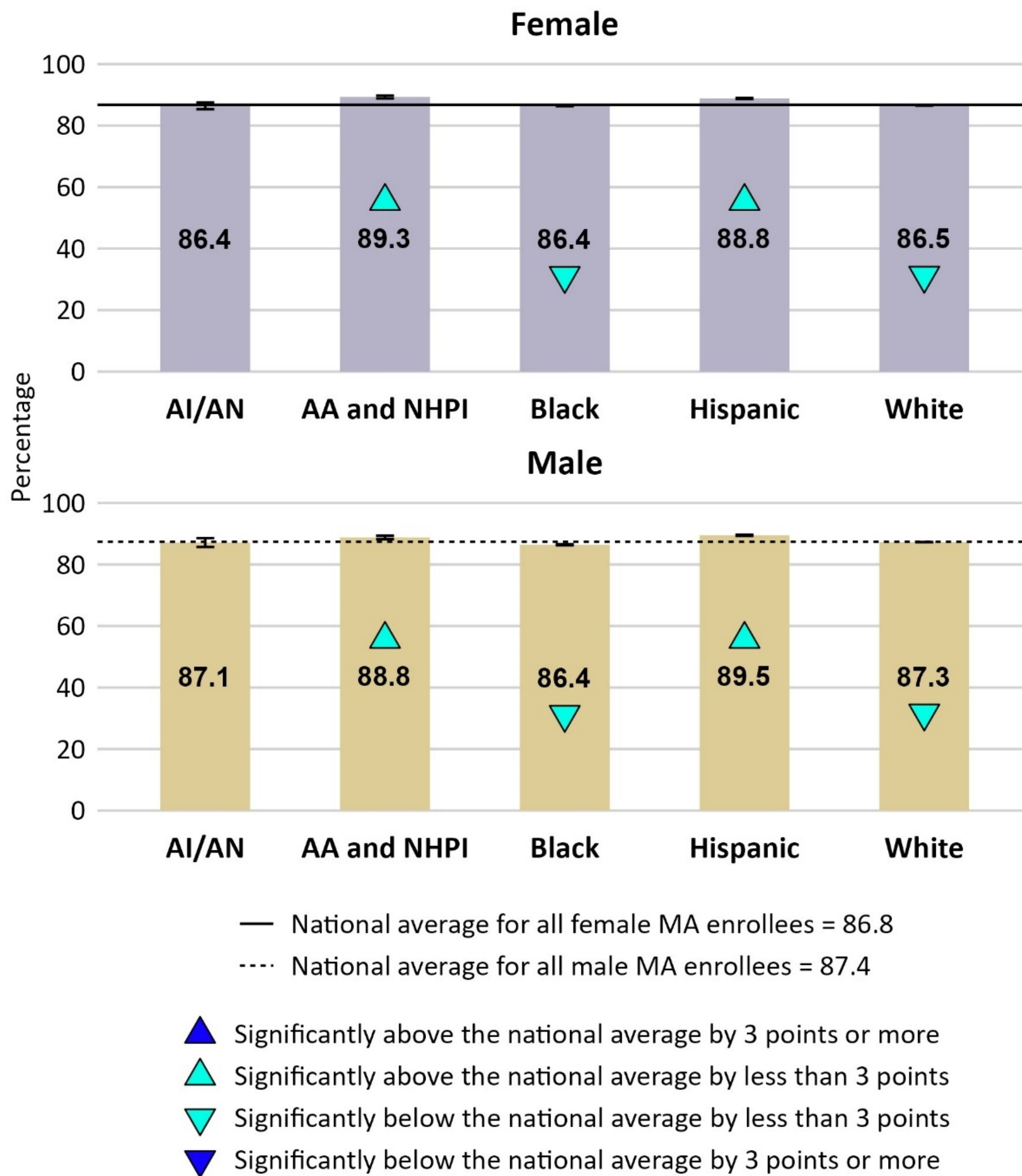
[†] Average morphine equivalent dose ≥ 90 mg.

Disparities

- The percentages of female AI/AN and White MA enrollees for whom use of opioids at a high dosage was avoided were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female AA and NHPI, Black, and Hispanic MA enrollees for whom use of opioids at a high dosage was avoided were each **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN and White MA enrollees for whom use of opioids at a high dosage was avoided were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male AA and NHPI MA enrollees for whom use of opioids at a high dosage was avoided was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentages of male Black and Hispanic MA enrollees for whom use of opioids at a high dosage was avoided were each **above** the national average for all male MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids from Multiple Prescribers

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more prescribers in the past year, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentage of female AI/AN MA enrollees for whom use of opioids from multiple prescribers was avoided was **similar to** the national average for all female MA enrollees. The percentages of female AA and NHPI and Hispanic MA enrollees for whom use of opioids from multiple prescribers was avoided were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female Black and White MA enrollees for whom use of opioids from multiple prescribers was avoided were each **below** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of male AI/AN MA enrollees for whom use of opioids from multiple prescribers was avoided was **similar to** the national average for all male MA enrollees. The percentages of male AA and NHPI and Hispanic MA enrollees for whom use of opioids from multiple prescribers was avoided were each **above** the national average for all male MA enrollees by less than 3 percentage points. The percentages of male Black and White MA enrollees for whom use of opioids from multiple prescribers was avoided were each **below** the national average for all male MA enrollees by less than 3 percentage points.

Avoiding Use of Opioids from Multiple Pharmacies

Percentage of MA enrollees aged 18 years and older who did not receive prescriptions for opioids from four or more pharmacies in the past year, by race and ethnicity within sex, Reporting Year 2023

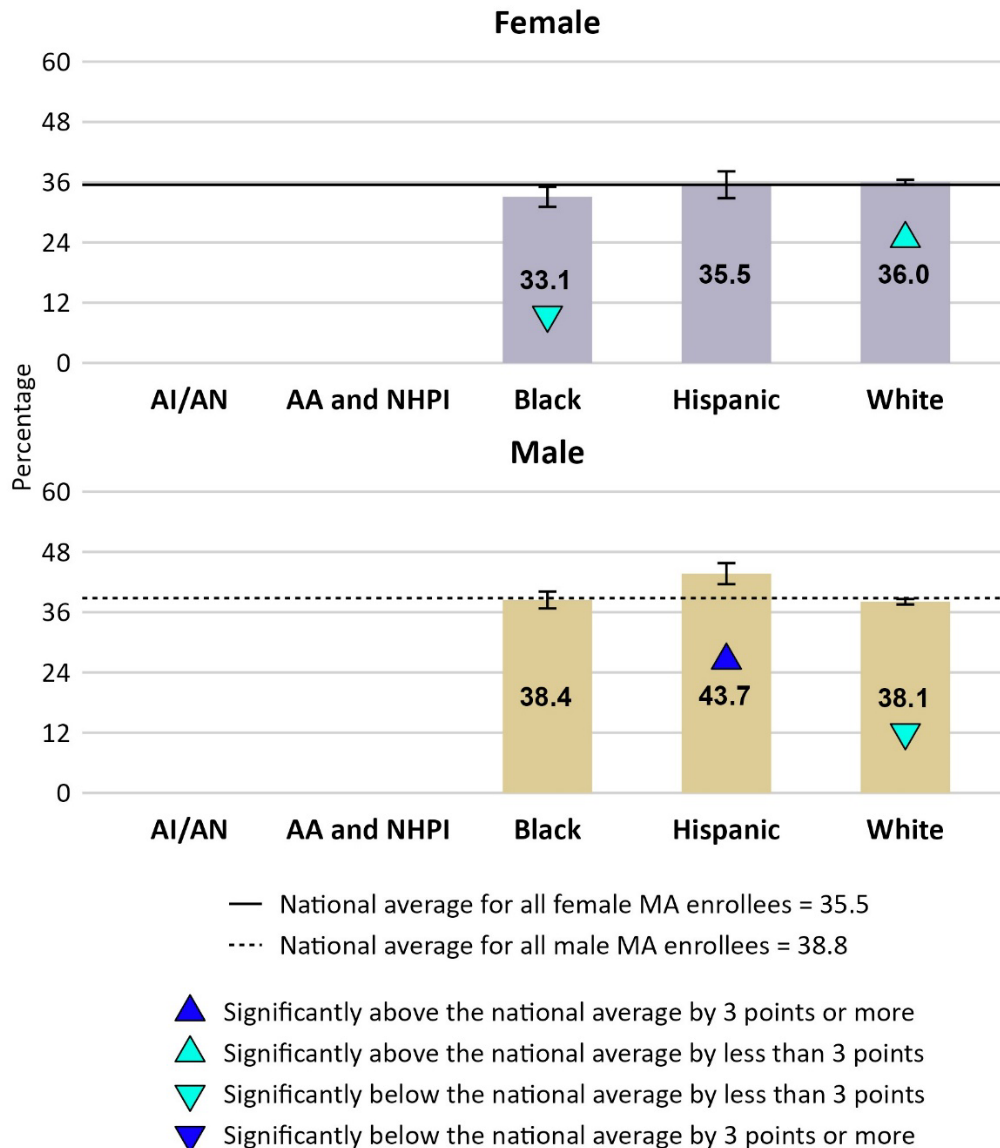
SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of female AI/AN and Black MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female AA and NHPI and White MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees for whom use of opioids from multiple pharmacies was avoided was **similar to** the national average for all female MA enrollees.
- The percentages of male AI/AN and AA and NHPI MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **similar to** the national average for all male MA enrollees. The percentages of male Black and Hispanic MA enrollees for whom use of opioids from multiple pharmacies was avoided were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees for whom use of opioids from multiple pharmacies was avoided was **above** the national average for all male MA enrollees by less than 3 percentage points.

Pharmacotherapy for Opioid Use Disorder

Percentage of opioid use disorder pharmacotherapy treatment events among MA enrollees aged 18 years and older† that continued for at least 180 days, by race and ethnicity within sex, Reporting Year 2023



— National average for all female MA enrollees = 35.5

---- National average for all male MA enrollees = 38.8

▲ Significantly above the national average by 3 points or more

△ Significantly above the national average by less than 3 points

▽ Significantly below the national average by less than 3 points

▼ Significantly below the national average by 3 points or more

SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races. The scores for female and male AI/AN and AA & NHPI MA enrollees are not accurate enough to report. Although the possible range of scores for this measure is from 0 to 100, both group means are below 50, so the y-axis for this graph is limited to 0 to 60 to improve legibility.

---

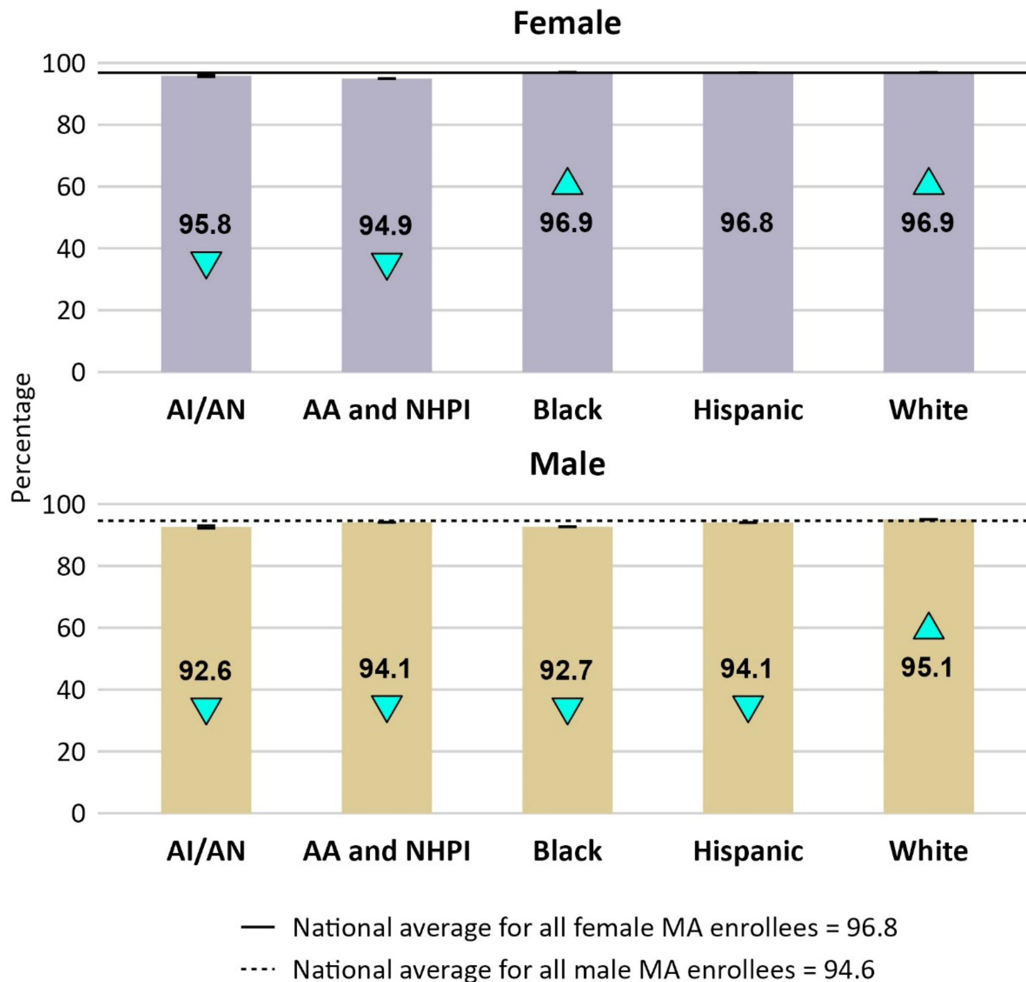
† Although the lower-bound age cutoff for this HEDIS measure is 16 years old, the data used in this report are limited to adults.

Disparities

- The percentage of opioid use disorder pharmacotherapy treatment events among female Black MA enrollees that continued for at least 180 days was **below** the national average for all female MA enrollees by less than 3 percentage points. The percentage of opioid use disorder pharmacotherapy treatment events among female Hispanic MA enrollees that continued for at least 180 days was **similar to** the national average for all female MA enrollees. The percentage of opioid use disorder pharmacotherapy treatment events among female White MA enrollees that continued for at least 180 days was **above** the national average for all female MA enrollees by less than 3 percentage points.
- The percentage of opioid use disorder pharmacotherapy treatment events among male Black MA enrollees that continued for at least 180 days was **similar to** the national average for all male MA enrollees. The percentage of opioid use disorder pharmacotherapy treatment events among male Hispanic MA enrollees that continued for at least 180 days was **above** the national average for all male MA enrollees by more than 3 percentage points. The percentage of opioid use disorder pharmacotherapy treatment events among male White MA enrollees that continued for at least 180 days was **below** the national average for all male MA enrollees by less than 3 percentage points.

Adult Access to Preventive and Ambulatory Services

Percentage of MA enrollees aged 20 years and older who had an ambulatory or preventive care visit in the past year, by race and ethnicity within sex, Reporting Year 2023



SOURCE: Clinical quality data were collected in 2022 from MA plans nationwide.
NOTES: AI/AN = American Indian and Alaska Native. AA and NHPI = Asian American and Native Hawaiian or other Pacific Islander. Racial groups, such as Black and White, are non-Hispanic. Hispanic ethnicity includes all races.

Disparities

- The percentages of female AI/AN and AA and NHPI MA enrollees who had an ambulatory or preventive care visit in the past year were each **below** the national average for all female MA enrollees by less than 3 percentage points. The percentages of female Black and White MA enrollees who had an ambulatory or preventive care visit in the past year were each **above** the national average for all female MA enrollees by less than 3 percentage points. The percentage of female Hispanic MA enrollees who had an ambulatory or preventive care visit in the past year was **similar to** the national average for all female MA enrollees.
- The percentages of male AI/AN, AA and NHPI, Black, and Hispanic MA enrollees who had an ambulatory or preventive care visit in the past year were each **below** the national average for all male MA enrollees by less than 3 percentage points. The percentage of male White MA enrollees who had an ambulatory or preventive care visit in the past year was **above** the national average for all male MA enrollees by less than 3 percentage points.

Appendix D: Data Source and Methods

The Medicare Consumer Assessment of Healthcare Providers and Systems Survey

The Medicare CAHPS surveys are a set of mail surveys with telephone follow-ups based on a stratified random sample of people with Medicare; contracts (referred to as *plans* in this report) serve as strata for MA enrollees and for people with Medicare FFS coverage who are enrolled in PDPs, and states serve as strata for people with Medicare FFS coverage who are not enrolled in PDPs. These surveys are administered nationally each year; the data presented in this report are from the 2023 surveys and pertain only to MA enrollees.

The 2023 Medicare CAHPS surveys, fielded March to June 2023, attempted to contact 1,129,395 people with Medicare and received responses from 391,298 people, for a 34.6-percent response rate. The 2023 surveys represent all people with Medicare FFS coverage, MA enrollees from 595 MA contracts that either were required to report (minimum of 600 eligible enrollees) or reported voluntarily (450–599 enrollees), and PDP enrollees from 51 PDP contracts with at least 1,500 eligible enrollees. More information on these surveys can be found on the MA and Prescription Drug Plan CAHPS page at CMS.gov (CMS, 2023d).

The Healthcare Effectiveness Data and Information Set

The HEDIS consists of more than 90 measures across six domains of care (National Committee for Quality Assurance, undated-a). These domains are effectiveness of care, access to and availability of care, experience of care, utilization and risk-adjusted utilization, relative resource use, and health plan descriptive information. HEDIS measures are developed, tested, and validated under the direction of the National Committee for Quality Assurance. Although CAHPS data are collected only via surveys, HEDIS data are gathered both via surveys and via medical charts and insurance claims or encounter data for hospitalizations, medical office visits, and procedures. Detailed information about these data can be found on the National Committee for Quality Assurance's HEDIS webpage (National Committee for Quality Assurance, undated-b). In selecting HEDIS measures to include in this report, we excluded measures that underwent a recent change in specification, were similar to reported measures preferred by CMS, or were deemed unsuitable for this application by CMS experts. In Reporting Year 2023, there were 734 MA contracts that supplied the 26,867,324 HEDIS measure records used for this report.

Information on Race and Ethnicity

The 2023 CAHPS survey asked respondents, "Are you of Hispanic or Latino origin or descent?" The response options were: "Yes, Hispanic or Latino" and "No, not Hispanic or Latino." The survey then asked, "What is your race? Please mark one or more," with response options of "White," "Black or African American," "Asian," "Native Hawaiian or other Pacific Islander," and "American Indian or Alaska Native." We followed a U.S. Census approach, so answers to these two questions were used to classify respondents into one of seven mutually exclusive categories: AI/AN, AA and NHPI, Black, Hispanic, Multiracial, White, or unknown:

- Respondents who endorsed Hispanic ethnicity were classified as Hispanic regardless of the races they endorsed.
- Non-Hispanic respondents who endorsed two or more races were classified as Multiracial, with a single exception: Respondents who selected both "Asian" and "Native Hawaiian or other Pacific Islander" and no other race were classified as AA and NHPI.
- Non-Hispanic respondents who selected exactly one race were classified as AI/AN, AA and NHPI, Black, or White, according to their responses.

- Respondents without data on race and ethnicity (about 4 percent) were classified as unknown.
- Unknown cases were dropped from the analyses of differences by race and ethnicity.

HEDIS data, unlike CAHPS data, do not contain the patient's self-reported race and ethnicity. Therefore, we imputed race and ethnicity for the HEDIS data using a methodology that combines information from administrative data, first and last name, and residential location (Haas et al., 2019). This methodology, which is known as Medicare Bayesian Improved Surname Geocoding (MBISG), produces for each person a set of racial and ethnic predicted probabilities (one each for AA and NHPI, AI/AN, Black, Hispanic, Multiracial, and White) that sum to one. MBISG 2.1 probabilities are strongly predictive of self-reported race and ethnicity. Predictive accuracy is measured using the C-statistic, also called the Concordance Statistic or Area Under the Curve, a common metric for the performance of classification models. The C-statistic summarizes the algorithm's sensitivity and specificity, with values of 0.5, 0.7, 0.8, 0.9, and 1.0 indicating chance, acceptable, excellent, outstanding, and perfect prediction, respectively (Hosmer, Lemeshow, and Sturdivant, 2013). C-statistics for MBISG 2.1 are outstanding for AA and NHPI, Black, Hispanic, and White MA enrollees (0.96–0.99), and excellent for AI/AN MA enrollees (0.85). Here we define race and ethnicity with a mutually exclusive classification variable constructed from the MBISG probabilities. To construct classifications, each case is initially classified into the racial or ethnic group with the highest MBISG probability across their set of six probabilities. Very few cases are classified into the Multiracial group using this rule, and classification into this group is not strongly predictive of self-reported race and ethnicity. Therefore, cases for which Multiracial is the highest probability are classified into the group indicated by their second-highest MBISG probability. Scores on clinical care measures are reported for AI/AN, AA and NHPI, Black, Hispanic, and White MA enrollees whenever the reporting criteria specified below are met.

Information on Sex

Information on the sex of MA enrollees is gathered from administrative records.

Reportability of Information

Scores based on 400 or more observations were considered sufficiently precise for reporting patient experience scores for all racial and ethnic groups and for reporting clinical care scores for AA and NHPI, Black, Hispanic, and White MA enrollees. Scores based on more than 99 but fewer than 400 observations were considered low in precision and were flagged as such.[18] Flagged scores—which should be regarded as tentative information—are shown unbolded with a superscript symbol appended; the symbol links to a note at the bottom of the chart that cautions about the precision of the score. Scores based on 99 or fewer observations are suppressed (i.e., not reported). When a score is suppressed for a particular group, a note at the bottom of the relevant chart states that there were not enough data from that group to make a racial and ethnic comparison on the measure. The algorithm used to predict AI/AN group membership for the clinical care data—although adequate in many cases—is not as good as it is for predicting membership in other racial or ethnic groups. Accordingly, stricter criteria are required for reporting clinical care scores for AI/AN MA enrollees. Here, we required a minimum sample size of 3,000

[18] A sample size of 400 ensures that the margin of error for a dichotomous measure is no greater than 5 percent. With a sample size of 100, the maximum margin of error is 10 percent.

observations for measures for which sampling weights are employed,[19] or 300 observations for all other measures. Clinical care scores for AI/AN MA enrollees not meeting these stricter criteria are suppressed.

Analytic Approach

The CAHPS measures presented in this report are composite measures that summarize, through averaging, the answers to two or more related CAHPS survey questions, or items. The annual flu vaccine measure is included in the CAHPS survey and is thus grouped with other CAHPS measures in this report. This is a single-item measure rather than a composite.

CAHPS patient experience scores for different racial and ethnic groups were estimated from case mix–adjusted linear regression models. Each model was run six times, with AI/AN, AA and NHPI, Black, Hispanic, Multiracial, and White MA enrollees successively serving as the focal racial or ethnic group. Each time the model was run, it contained records for MA enrollees of all racial and ethnic groups; what changed were predictors. These linear regression models contained an indicator for the focal racial or ethnic group and the following case-mix adjustors: age, education, self-rated health and mental health, dual eligibility/low-income subsidy, and proxy status. No adjustment was made for survey language. In keeping with how the measure is officially scored, no case-mix adjustment was made for the annual flu vaccine measure. These models yielded estimates of each group's score and a statistical test of the difference between that score and the score for all others; the statistical test is mathematically equivalent to the test of the difference of the group's score from the national average for all MA enrollees.

CAHPS scores for female and male MA enrollees were estimated from linear regression models—case-mix adjusted for the patient experience measures—that contained either an indicator for female sex or an indicator for male sex.

CAHPS scores for female and male MA enrollees of different racial and ethnic backgrounds were estimated from linear regression models, case-mix adjusted for the patient experience measures, that were stratified by sex. These models were constructed in the same manner as the overall racial and ethnic models. These models yielded estimates of each racial and ethnic group's score in each sex stratum and a statistical test of the difference between that score and the score for all others; the statistical test is mathematically equivalent to the test of the difference of the group's score from the national average for all female or male MA enrollees (depending on the stratum).

HEDIS estimates for different racial and ethnic groups are from logistic regression models. Each model was run five times, each time focusing on a single racial or ethnic group: AI/AN, AA and NHPI, Black, Hispanic, and White. None of the HEDIS measures reported is case-mix adjusted. That is, the sole predictor in each logistic regression model was a single indicator that a person belonged to the focal racial or ethnic group for that model according to MBISG-based classifications. HEDIS estimates for female and male MA enrollees are from logistic regression models that contained only an indicator for female or male sex. HEDIS estimates for female and male MA enrollees of different racial and ethnic groups are from logistic regression models, stratified by sex, that were run in the same manner as the overall racial and ethnic models described earlier. To estimate the confidence interval for the difference between the score for one group and the national mean, a linear regression that was otherwise similar to

[19] For a subset of the HEDIS measures included in this report, plans may choose between complete case reporting and a chart-based sampling method of reporting. To account for differences in reporting methods, sampling weights were developed and used in all analyses for each applicable measure. These weights are equal to a plan's eligible population divided by the number of HEDIS patient-level records received from that plan.

the model described earlier (with the racial or ethnic group indicator as the sole predictor) was run, retaining the standard error of the log-odds for the group identifier. This standard error was multiplied by the proportion of MA enrollees not in the group to estimate the standard error for the difference, which was then used to construct the confidence interval. As noted previously, regression models included sampling weights for the subset of HEDIS measures for which sampling may be employed for reporting.

In comparisons of estimated scores with the national average, a difference is denoted as statistically significant if there is less than a 5-percent chance that the difference could have resulted because of sampling error alone. Differences that are statistically significant and larger than 3 points on a 0–100 scale (CAHPS) or 3 percentage points (HEDIS) are further denoted as practically significant. In the summary charts that appear in the report and at the beginning of each appendix that show measure-by-measure results, the focus is on practically significant differences. In the charts that present results on individual measures of patient experience (CAHPS) and clinical care (HEDIS), the focus is on statistically significant differences. In these charts, statistically significant differences that are less than 3 points in magnitude are distinguished from statistically and practically significant differences that are 3 points in magnitude or larger through the coloring of the upward- and downward-facing arrows that appear in the bars. Turquoise arrows indicate statistically significant differences that are less than 3 points in magnitude; dark blue arrows indicate statistically significant differences that are 3 points in magnitude or larger. The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).

References

Agency for Healthcare Research and Quality, “Topic: Diabetes,” webpage, undated. As of February 5, 2024:
https://www.ahrq.gov/topics/diabetes.html

Centers for Disease Control and Prevention, *National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden in the United States*, 2020.

Centers for Medicare & Medicaid Services, *Diabetes Disparities in Medicare Fee-for-Service Beneficiaries*, November 2021.

Centers for Medicare & Medicaid Services, “Managing Diabetes: Coverage & Resources,” fact sheet, May 2022.

Centers for Medicare & Medicaid Services, “Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly.” *Federal Register*, Vol. 88, No. 70, April 12, 2023a.

Centers for Medicare & Medicaid Services, “5 Things to Know About Medicare Insulin Costs,” fact sheet, July 2023b.

Centers for Medicare & Medicaid Services, *Medicare Diabetes Prevention and Diabetes Self-Management Training*, August 2023c.

Centers for Medicare & Medicaid Services, “Medicare Advantage and Prescription Drug Plan CAHPS (MA and PDP CAHPS),” webpage, last updated September 6, 2023d. As of December 4, 2023:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/mcahps

Centers for Medicare & Medicaid Services, “Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs,” *Federal Register*, Vol. 88, No. 224, November 22, 2023e.

Centers for Medicare & Medicaid Services, “Stratified Reporting,” webpage, updated November 29, 2023f. As of December 4, 2023:
https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting

Centers for Medicare & Medicaid Services, “CMS Announces New Model to Advance Integration in Behavioral Health,” press release, January 18, 2024a.

Centers for Medicare & Medicaid Services, “Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024—Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE),” unpublished rule, *Federal Register*, April 4, 2024b.

CMS—*See* Centers for Medicare & Medicaid Services.

Figueroa, Jose F., Jessica Phelan, E. John Orav, Vikram Patel, and Ashish K. Jha, "Association of Mental Health Disorders with Health Care Spending in the Medicare Population," *JAMA Network Open*, Vol. 3, No. 3, 2020.

Haas, Ann, Marc N. Elliott, Jacob W. Dembosky, John L. Adams, Shondelle M. Wilson-Frederick, Joshua S. Mallett, Sarah Gaillot, Samuel C. Haffer, and Amelia M. Haviland, "Imputation of Race/Ethnicity to Enable Measurement of HEDIS Performance by Race/Ethnicity," *Health Services Research*, Vol. 54, No. 1, 2019, pp. 13–23.

Hosmer, David W., Jr., Stanley Lemeshow, and Rodney X. Sturdivant, *Applied Logistic Regression*, 3rd ed., Hoboken, N.J.: John Wiley & Sons, 2013.

Indian Health Service, *Special Diabetes Program for Indians: 2020 Report to Congress*, 2020.

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* Washington, D.C.: National Academies Press, 2001.

Martino, Steven C., Robin N. Weinick, David E. Kanouse, Julie A. Brown, Amelia M. Haviland, Elizabeth Goldstein, John L. Adams, Katrin Hambarsoomian, David J. Klein, and Marc N. Elliott, "Reporting CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries," *Health Services Research*, Vol. 48, No. 2, 2013, pp. 417–434.

Mayer, Lauren A., Marc N. Elliott, Ann Haas, Ron D. Hays, and Robin M. Weinick, "Less Use of Extreme Response Options by Asians to Standardized Care Scenarios May Explain Some Racial/Ethnic Differences in CAHPS Scores," *Medical Care*, Vol. 54, No. 1, 2016, pp. 38–44.

McGinty, Beth. "Medicare's Mental Health Coverage: What's Included, What's Changed, and What Gaps Remain," Commonwealth Fund, March 2, 2023.

Medicare.gov, "Find a Medicare Plan," webpage, undated. As of December 4, 2023: https://www.medicare.gov/plan-compare/#/?year=2024&lang=en

Meyers, David J., Vincent Mor, Momotazur Rahman, and Amal N. Trivedi, "Growth in Medicare Advantage Greatest Among Black and Hispanic Enrollees," *Health Affairs*, Vol. 40, No. 6, June 2021, pp. 945–950.

National Committee for Quality Assurance, "HEDIS and Performance Measurement," webpage, undated-a. As of December 4, 2023:
https://www.ncqa.org/hedis/

National Committee for Quality Assurance, "HEDIS Measures and Technical Resources," webpage, undated-b. As of December 4, 2023:
https://www.ncqa.org/hedis/measures/

Ochieng, Nancy, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, "Medicare Advantage in 2023: Enrollment Update and Key Trends," Kaiser Family Foundation, August 9, 2023.

Paddison, Charlotte A. M., Marc N. Elliott, Amelia M. Haviland, Donna O. Farley, Georgios Lyratzopoulos, Katrin Hambarsoomian, Jacob W. Dembosky, and Martin O. Roland, “Experiences of Care Among Medicare Beneficiaries with ESRD: Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results,” *American Journal of Kidney Diseases*, Vol. 61, No. 3, March 2013, pp. 440–449.

Villarroel, Maria A., Anjel Vahratian, and Brian W. Ward, “Health Care Utilization Among U.S. Adults with Diagnosed Diabetes, 2013,” *NCHS Data Brief*, No. 83, February 2015, pp. 1–8.

Copyright Information

This communication was produced, published, and disseminated at U.S. taxpayer expense. All material appearing in this report is in the public domain and may be reproduced or copied without permission; citation as to source, however, is appreciated.

Disclaimer

This document contains links to non–United States Government websites. We are providing these links for reference only; linking to a non–United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

Suggested Citation

Martino, SC, Elliott, MN, Dembosky, JW, Hambarsoomian, K, Klein, DJ, Lee, J, Gildner, J, and Haviland, AM. *Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex*. Baltimore, MD: CMS Office of Minority Health. 2024.